Exhibit 1

Transcript of Matthew Hyzy, M.D.

Date: June 17, 2022
Case: Palmquist, et al. -v- The Hain Celestial Group, Inc., et al.

Planet Depos
Phone: 888.433.3767
Email: transcripts@planetdepos.com
www.planetdepos.com

1

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
GALVESTON DIVISION
Case No. 3:21-CV-90

VIDEO-RECORDED DEPOSITION OF MATTHEW HYZY
June 17, 2022

SARAH PALMQUIST, Individually and as Next Friend of E.P., a Minor, and GRANT PALMQUIST,
Plaintiffs,
vs.
THE HAIN CELESTIAL GROUP, INC.,
Defendant.

APPEARANCES:

PARKER & SANCHEZ, PLLC
By Charles Parker, Esq.
700 Louisiana Street
Suite 2700
Houston, Texas 77002
713.659.7200
charlie@parkersanchez.com
Appearing on behalf of Plaintiffs

Covington & Burling, LLP
By Kathleen E. Paley, Esq.
One CityCenter
850 Tenth Street, NW
Washington, DC 20001
202.662.5641
kpaley@cov.com
Appearing on behalf of Defendant

ALSO PRESENT: Dwayne Beuthel, Videographer

2

Pursuant to Notice and the Federal Rules of Civil Procedure, the deposition of MATTHEW HYZY, called by Defendant, was taken on Friday, June 17, 2022, commencing at 8:07 a.m., at 9777 South Yosemite Street, Suite 200, Lone Tree, Colorado, before Barbara J. Davalos, Registered Merit Reporter and Certified Realtime Reporter within and for the State of Colorado.

3

I N D E X

4

I N D E X (Continued)

PREVIOUSLY MARKED EXHIBITS

None

5

P R O C E E D I N G S

THE VIDEOGRAPHER: We are on the record at 8:07 a.m. Today is June 7th -- 17th, 2022. This begins the video-recorded deposition of Matthew Hyzy taken in the matter of Sarah Palmquist, et al. v. The Hain Celestial Group.

This deposition is being taken at 977 South Yosemite Street in Lone Tree, Colorado. The court reporter is Barbara Davalos. The videographer is Dwayne Beuthel.

Counsel will introduce themselves and the parties they represent beginning with the plaintiffs' counsel first.

MR. PARKER: Charlie Parker representing the Palmquist family.

MS. PALEY: Kathleen Paley representing Hain Celestial.

THE VIDEOGRAPHER: Will our court reporter please swear in the deponent.

MATTHEW HYZY,

being first duly sworn in the above cause, was examined and testified as follows:

THE VIDEOGRAPHER: You may begin.

6

EXAMINATION

BY MS. PALEY:

Q All right. Good morning, Dr. Hyzy.

A Good morning.

MR. PARKER: Can I do one thing real quick. Of course we want to read and sign, and can I have the agreement to read and sign before any notary public?

THE REPORTER: Before a notary public?

MR. PARKER: Before any notary public.

MS. PALEY: Oh. Yeah. I mean, as in any notary public would be sufficient?

MR. PARKER: Right.

MS. PALEY: That's fine.

MR. PARKER: Great.

MS. PALEY: It doesn't have to be a specific state, et cetera?

MR. PARKER: Correct.

MS. PALEY: Understood. That's fine.

Q (BY MS. PALEY) All right. So I know you've been deposed before, so I'll be brief with all the preliminaries. Can we agree to give each other time to ask a whole question and complete a whole answer, and just try not to step on each other for the sake of the court reporter?

7

A Yes, ma'am.

Q Okay. And if I ever step on you because I don't realize you're finished, you know, with an answer, my apologies. I'll try my best not to do that, but glad we can both do that.

If you need any clarification of my questions, please let me know. Is that okay?

A Yes.

Q And I think we should probably aim to take brief breaks every hour or so. But if you need any break that's not on the hour, just let me know. We can finish the pending question, and then we can take a break. Okay?

A Okay.

Q All right. I'm going to mark for the record the notice of deposition sent out in this case. This will be Exhibit 1.

(Exhibit Number 1 was marked.)

MS. PALEY: Charlie, I'll give you the backup.

And Elizabeth, our --

MR. PARKER: Let's see. You got one marked for him?

MS. PALEY: Here we go. Yep. Here's the marked version.

8

MR. PARKER: Okay. I've got two.

MS. PALEY: All right.

Q (BY MS. PALEY) I apologize. We have the luxury of a large conference room today, so there's going to be a lot of reaching. Also our associate wasn't able to make it. So that -- hence, another, you know, long reach here rather than having her do it.

MR. PARKER: We're going to give you extra time for that.

MS. PALEY: Thank you.

Q (BY MS. PALEY) All right. Do you see Exhibit 1, the notice of deposition?

A Yes, ma'am.

Q And did you receive this before today?

A I did.

Q And did you review Exhibit A, which is the final page of the notice?

A I did.

Q Okay. And did you bring any documents with you today, sir?

A I did not.

Q Okay. Let's just run through these very quickly. Item 1 on the Exhibit A, do you have any materials that are responsive to Item 1 that you

9

haven't produced before today?
A Everything has been produced.
Q Okay. And so let me just then sort of zoom in on Items 5 through 7, just to clarify my understanding. Item 5 asks for all documents relating to the deponent's cost survey in the life care plan of Ethan Palmquist, including notes from calls or meetings or any materials received from the providers who are referenced in the life care plan.
Do you have any such notes, materials received, anything related to your cost survey?
A There are no other documents other than what's published in my life care plan.
Q Okay.
MR. PARKER: And in the documents that we provided to you.
Q (BY MS. PALEY) And we received a set of documents yesterday which appeared to be maybe some forms that Dr. Palmquist had filled out and some invoices. But I haven't seen any notes from the cost survey efforts or any materials received from providers who are referenced in the cost survey.
A So there are no notes, just those specific files that I think you both are discussing. And I don't typically take handwritten notes for my type of

10

work, dictations, history, et cetera, or physician meetings, phone-to-phone meetings. So there's nothing else on Number 5 that I could produce today.
Q So how -- when you get on the phone --
MR. PARKER: Hold on just one second, sir. So I've got a copy of the email that -- and I can send it to you, but everything that we sent him we sent you a copy of. You've got that?
MS. PALEY: I've got that.
MR. PARKER: Okay. That was --
MS. PALEY: Yes.
MR. PARKER: Okay.
MS. PALEY: I just wanted to know if there were any notes from his cost survey.
MR. PARKER: Okay.
MS. PALEY: When he called a certain pediatric dentist, did he have notes? When he talked to Avondale House, were there notes?
MR. PARKER: I was worried for a second, you hadn't -- there was a mix-up.
MS. PALEY: I received that. Thank you, Charlie.
Q (BY MS. PALEY) So Doctor, when you do these cost surveys -- well, first of all, is it you who's calling the providers to get their costs?

11

A I typically do not call the providers, given my busy clinical schedule. So typically one of my team members we delegate this to. We have an educate and train team at Physician Life Care Planning to do that cost survey analysis.
Q So PLCP, is that the acronym for Physician Life Care Planning?
A That's correct.
Q And that's the organization that you've contracted with to do today's work, correct?
A That's correct.
Q And do those individuals who make the calls to, say, a pediatric dentist or a specialty school, do they have any notes?
A It's my understanding that there are no notes. They have the document or the specific vendor, the cost. That gets sent to me and I review it. If I need to validate it, I may or may not call them to validate, depending on my experience with the actual charge.
Q And so when you say they have the document or the specific vendor --
A Uh-huh.
Q -- the costs that get sent to me, what do you mean by that? What documents do they have?

12

A So if they were to pull a cost for a specific procedure, a medication or something like Avondale House, then that is sent to me as I'm building and drafting my life care plan. And so if that is questionable on my end, then I may verify it by calling them myself. But given my busy clinical practice, it's not my standard to verify every single thing. I need to delegate to my staff to do that.
Q And so you've received emails or other communications from the PCLP folks who call the vendors, correct?
A Not exactly correct.
Q What have you received from them? You said --
A PLC- --
Q PLCP.
A -- Physician Life Care Planning --
THE REPORTER: I'm sorry --
A What was your question, Ms. Payne [sic]?
Q (BY MS. PALEY) You say, If they were to pull a cost for a specific procedure, a medication or something like that, they send it to me.
How do they send it to you?
A Well, we have a working product. And so depending on how that day plays out, it could be a

13

phone call or it could be in my working product, which would be like a draft of my life care plan before I finalize it.

Q And is that working product, is that something that both you and the PLCP -- PLCP folks can access at the same time, something like a Google Doc? I mean, not that specifically but --

A Sort -- excuse me. And I'm sorry, Ms. Paley, P-a-l-e-y?

Q Correct.

A Okay. I think I misspoke earlier. So not exactly like a Google Drive. The life care plan is my plan. I authored it and reviewed every word. And so they're able to give me information that then I plug into there. But it's not similar to a Google Drive business document where you're just adding realtime, where multiple people have access to that. It's definitely not that.

Q Okay. And so the folks at PLCP, they may have notes or documents from the vendors. They didn't send them to you, but you discussed the material with them; is that correct?

A Well, I can't comment if they have specific dots -- excuse me, documents or notes, because that would be part of our working product.

14

What I am reviewing is the actual numbers, the costs, CPT codes, things like that, that I am providing to them on my recommendations to then source or do our cost vendor analysis.

Q All right.

MS. PALEY: And Charlie, we can deal with this, you know, later and separately. But I'd like to call for the production of any notes, materials, anything that would be responsive to Request 5 here that would be in the possession of Physician Life Care Planning but not Dr. Hyzy specifically.

MR. PARKER: If you will send me an email to that effect when we finish, I will be glad to see if there are any such documents.

MS. PALEY: I can do that.

Q (BY MS. PALEY) Item 6 on the notice of deposition is, All documents relating to the deponent's telephone conferences with Dr. Krigsman, Dr. Rotenberg, Dr. Settles and/or Dr. Nelson, including any notes or calls from those telephone conferences.

Do you have any notes or other documentation of those conferences?

A Other than what is documented in my life care plan, there are no other notes, handwritten

15

notes or documents. I don't typically take handwritten notes. When I do a physician-to-physician, peer-to-peer -- and that's something that I do frequently, discussing with neurosurgeons, neurologists or even like insurance authorization folks for hospital-based stuff. And so there are no handwritten notes or documents relating to those specific phone calls.

Q And I think I know the answer, but I'll just ask the question. You didn't record those phone calls, did you?

A They are not recorded.

Q Okay. Item 7 is -- if you need to take a break for water at any point, I understand. It's very dry in here.

A Welcome to Colorado.

Q We both have our water bottles.

MR. PARKER: For Item 7, as I discussed with Elizabeth, the UCR80 survey is under a license agreement, and we -- he cannot produce it. And if you want to follow it up, we're glad to produce the license agreement and give everybody notice and do all that.

MS. PALEY: Understood. Thank you. And I got notice of that yesterday, Charlie.

16

MR. PARKER: Okay.

Q (BY MS. PALEY) So I just want to ask one question about the UCR80 survey.

A Uh-huh.

Q When doing the UCR80 survey, do you personally get into the Context 4 Healthcare database to look up those 80th percentile costs? Or is that also done by the staff at Physician Life Care Planning?

A I do delegate to the staff. If there is a major concern or question, I may access it to verify something. But given what I do for a living, I typically don't need to because it's very transparent and consistent with what kind of I know as billable charges.

Q Okay. So just to round this out, are there any other materials that you considered beyond what's identified in your report -- listed in your report as materials that you considered and beyond the materials that Mr. Parker sent us yesterday, which includes a list of like medical records?

A There are no other materials.

Q And does your report include the full scope of your opinions in this case?

A It does.

17

Q Okay.
A Ms. Paley?
Q Yes.
A Just to clarify, I am an osteopathic DO. And on the notice of deposition, it does have -- it listed as MD incorrectly.
Q Understood. Thank you. Thanks for noting that for the record.
Now for the sake of efficiency, I'm going to mark a bunch of the sort of basic documents right now as exhibits. We'll get them in front of you, and then you can move between them as needed. So this will be just a moment.
So I'm going to mark as Exhibit 2 -- just one moment here. I want to keep my documents straight.
MR. PARKER: Do you want me to come over there and outline your exhibits for you, for your assistant?
MS. PALEY: I told Elizabeth I would try to muddle through without her. It's been a while since I've flown solo on a deposition.
MR. PARKER: As I explained to Dr. Hyzy, I said, I'm old school. And he said, What do you mean by old school? You can take this down if you want.

18

And I showed him his full report with notes and tabs, et cetera.
Q (BY MS. PALEY) All right. We'll mark as Exhibit 2, which I'll send your way.
(Exhibit Number 2 was marked.)
A Thank you.
Q (BY MS. PALEY) This is your -- Dr. Hyzy, is this your CV?
A Correct.
Q Okay. And then we'll mark as Exhibit 3 --
(Exhibit Number 3 was marked.)
Q (BY MS. PALEY) Sorry. I didn't get that one far enough. And, Dr. Hyzy, Exhibit 3, is that your list of expert test- -- deposition -- strike that.
Is that your list of expert testimony given in the last four years?
A I did have a discovery deposition yesterday.
Q Okay.
A So that is not on this current list. I think that is the only one in addition to this current list.
Q Okay. And we will walk through the list in just a bit.

19

I'll mark as Exhibit 4 the physician -- I'm waiting for our court reporter, who's making do with a challenging chair. We'll mark as Exhibit 4 the Physician Life Care Planning retention agreement.
(Exhibit Number 4 was marked.)
Q (BY MS. PALEY) Is this familiar to you as the retention agreement in this case?
A Yes, ma'am.
Q Okay. We'll mark as Exhibit 5 --
MS. PALEY: Charlie, I believe this might be what you were referring to or one of the documents you were referring to.
Q (BY MS. PALEY) -- a list of docs to PLCP.
(Exhibit Number 5 was marked.)
MR. PARKER: Okay.
Q (BY MS. PALEY) Is this familiar to you as a list of materials that you received as part of your life care planning work, the first three pages here?
A That's correct.
Q Okay. And then we have a few invoices on the next pages. Do you see those?
A I do.
Q And do those look to be your invoices in this litigation?
A These would be the invoices from Physician Life Care Planning to the law firm.
Q Understood.
And then you received separate payment from Physician Life Care Planning?
A That is correct.
Q Okay. We're almost to the end of the great exhibit marking --
A Well, thank you --
Q -- exercise.
A -- for bringing all these. It's nice to stay organized and not burn all my printer paper.
Q I understand. The one benefit of being back in the office is that we now have -- we have our big, multifunction printers again.
So I'm going to mark as Exhibit 6 what I believe to be your online bio.
(Exhibit Number 6 was marked.)
Q (BY MS. PALEY) I just want to confirm that's what that is. Do you recognize this?
A This is my private practice.
Q Okay.
A Centeno-Schultz Clinic online bio as you described it.
Q And it mentions that you work in interventional orthobiologics; is that correct?

21

A That's correct.
Q What -- for the layperson, what does that mean? That sounds -- it sounds very fancy.
A So this is kind of a longer answer, if I may take the time to answer that.
Q Sure.
A So number one, you know, I graduated from medical school and then started physical medicine and rehabilitation residency. So completed that. And that is my board certification. And that includes numerous pediatric rotations and training in neurosurgery, neurology, orthopedics, pain management, interventional spine, sports medicine, hospital-based care, ICU, et cetera.
When I came to Colorado after Texas for my fellowship, my fellowship was here with my group, Centeno-Schultz Clinic, and our main office is north side of Denver. Today we're sitting at my satellite office here. And so that's an interventional spine pain management fellowship. So our practice is mostly that, but our research is under autologous orthobiologics. Autologous meaning from your own body.
Q Okay.
A And so that's mostly blood, platelet-rich

22

plasma and bone marrow concentrate. So the majority of my research publications and peer-reviewed journals are surrounding that treatment of the orthopedic or spine. And so the term orthobiologics is encompassing the body's own ability to heal, which is mostly the blood platelet-rich plasma or the bone marrow concentrate.
So I'm typically four days in clinic doing procedures, with a flex day, as well as still seeing patients in the hospital, training residents and med students, both hospital, classic physical medicine rehab, brain injury, spinal cord injuries, amputations and in the procedures in my clinic. So that, I think is the best way to answer that question.
Q Okay. Thank you. That was very informative.
(Exhibit Number 7 was marked.)
Q (BY MS. PALEY) All right. And then Exhibit 7 -- I'm about to lose my microphone. Exhibit 7 is a copy of your life care plan in this case. If you can just take a quick look and confirm that's what it is, that would be great.
A Without going through all 265 pages, this looks like the complete life care plan. Thank you

23

for providing that.
Q And we double-sided it to save a little bit of tree.
A I understand.
Q And I promise I haven't inserted anything in here that wasn't already in there already. So it should be the original.
All right. Let's talk about the process of preparing a life care plan.
A Yes.
Q Now, is the first step to understand what the patient's injuries are and what their medical needs are?
A Essentially the first step is before that on -- do I, as a physician, want to undertake the case or not. So specifically with Mr. Palmquist -- referring to Ethan, the minor -- I was contacted by the Arnold Lincoln law firm very early February, perhaps February 2nd. I had a phone call with their attorney, and he described the clinical situation.
And I explained to him my skill set and my experience with pediatric cases, whether it was like independent medical exams or pediatric life care plans.
So once we had that discussion, at that

24

point is when the other document you're referencing, I believe as Exhibit 4, our retention agreement. After that phone call, I believe that's when Roland Christensen, on behalf of Arnold Itkin, started the retention agreement to go through then the next steps in preparing the life care plan.
Q And -- thank you. That was helpful.
Do you know if Arnold & Itkin just sort of found you on their own or if it was Physician Life Care Planning that pointed them in your direction?
A Well, it would be Physician Life Care Planning, because there's numerous physicians. We're all the board certified physical medicine and rehabilitation physicians that work as independent contractors for Physician Life Care Planning. And so depending on the type of case or the specific experts' availability, timeframe, skill set, that's kind of how the law firm and the team at PLCP decide where the case can go.
Q Okay. And then what I had originally meant -- which I didn't clarify, but now we can turn to it is -- once you've decided that you're going to prepare a life care plan for a particular -- I won't say patient but client, is -- are the sort of initial steps understanding what's the injury and then

25

determining what's the medical need?
A So it's a little bit more involved and complex than that, Ms. Paley. So the initial steps are the law firm needs to upload all the medical records so I can start reviewing them. In this case, it was extensive. And then at that point, we schedule a interview or examination.
In this case, I started with Dr. Sarah Palmquist, the mother, over the phone to understand things. And then roughly a week later, I did a face-to-face visit with them in Texas at their house.
From there, I'm working on my dictation of their diagnoses, impairments, disabilities, moving into the entire 265 pages of my opinions. And then the future medical needs, then the cost analysis. And then I'm reviewing it before I finalize and send it back to the law firm.
Q Okay. But then your plan that you put together is not a -- it's not a prescription for care; is that correct?
A That's correct.
Q And I took that -- that language is probably familiar to you because it's taken directly from your report on page 4.
A Yes.

26

Q When you say it's not a prescription for care, what does that -- what does that mean?
A So when I am seeing patients in a hospital, I need to create medical orders for specific therapies and speech evaluations and cognitive evaluations, order seizure medications, get them discharged, et cetera, with a prescription for those things as they leave the hospital. Or in the clinic, you know, in my outpatient practice, the exact same process. We have to prescribe medical care, DMEs, referrals to other therapists or physicians or testing or imaging studies or medications.
When we are practicing medicine, we're usually staying in more of an acute phase. It could be four weeks, six weeks, 12 weeks. Some of my patients I see maybe every six months to nine months. So that would be a prescription for care.
But in a life care plan, it's different because it's an outline on what's -- in my opinion, what is going to be reasonable medical care, based upon his specific clinical indications, the diagnoses, the impairments, the duration of life expectancy, et cetera. So that would be, I think, the distinction.

27

Q Okay. And your report, in the same paragraph that talks about this not being a prescription for care, says, It represents a logical model of care which anticipates a medically related goods and services that will likely be required by Mr. Palmquist throughout the probable duration of care.
What do you mean by "likely be required"?
A So I am defining "likely be required" as within a reasonable degree of medical probability, directly related to his primary impairments and disabilities and diagnoses for the future.
Q And so can you say more likely than not that Ethan will need each of the goods and services outlined in your life care plan?
A I would agree. How I define "probable" and "more likely than not" would be 51 percent or greater. And there are some other areas I think where I did put that in my plan in slightly different language or vernacular though.
Q So when you say -- I just want to make sure I understand.
A Uh-huh.
Q When you say care would likely be required, you are defining that as more likely than

28

not?
A That's correct.
Q Okay. And can you say -- did I understand that as to the particulars of the -- you know, the type of care; you know, the -- the iPad, the bed, the visits to various specialists?
Now, can you say more likely than not that Ethan will need each of these goods and services listed in the plan with the -- with the frequency and duration that you outline in the plan?
A Yes. I would agree that would be probable and/or more likely than not, in my opinion, for those other types of medical-related goods and services.
Q Okay. And so, again, just to make sure I understand sort of the scope of how you're describing this work. Are you reco- -- not writing a prescription for care, but are you recommending that Ethan pursue or receive each kind of care listed in this life care plan?
A So recommendation is one way to describe it. Outlining it is another way to describe it. Using my life care plan as a template for his family and case managers and others would be another way to describe it. This life care plan is outlining, in my opinion, what would be optimal to then move back into

29

achieving my four clinical objectives of life care planning.

So it's -- again, I'm not prescribing it to him or his family, but it is something that could be described as recommended and outlined as a total plan or a guide for the family.

Q So is this -- in sort of sum, is this your best estimate of Ethan's like potential care needs?

A At the time of the completion, March 30th, absolutely, I would agree -- excuse me, March 30th, 2022.

Q Uh-huh.

A Yes. That would have been the best recommendations at that time.

Q So let's look at your report. I think we'll probably spend the most time in your report today. And Page 1, as numbered on the bottom right side of the report, you begin with an overview and an executive summary, Section 1.1.

A Yes.

Q And I'm just going to read that first sentence of the executive summary. This life care plan, this report has been prepared for Mr. Ethan Palmquist, a 7-year-old left-handed dominant male who suffered a severe acquired brain injury with global

30

neurodevelopmental delays and Crohn's disease secondary to heavy metal toxicity -- heavy metal toxicity with severe regression in May 2017.

I think I got that right. Is that correct?

A Yes, ma'am.

Q Okay. Now, again, just to make sure I understand the scope of your opinions here, are you offering a specific causation opinion in this case?

A I am not offering a specific causation opinion on Ethan's diagnoses other than what I have reviewed in the treating medical records regarding the heavy metal toxicity.

Q Okay. So have you independently evaluated the medical records, the metal testing results and, you know -- strike that. Just a second.

Have you independently evaluated the medical records in this case and the metal testing results and the testing results for Earth's Best Baby Foods to determine that it was those foods that caused Ethan to develop the cluster of diagnoses that you issue in this plan?

A Can we try to break down the question?

Q Sure.

A Because I heard numerous things of

31

records, medical records and labs and the food.

Q Yeah. So have you -- are you offering a specific causation opinion that it was eating Earth's Best Baby Food that caused Ethan to develop the cluster of I believe it's like 11 or 14 diagnoses that you put in this report?

A So my report is simple in taking Ethan with his diagnoses and the future care that I'm recommending. I'm not offering a specific causation opinion regarding what you're stating as Earth's Best Baby Food.

Q Okay. And are you -- based on your review of the materials that you listed in your materials considered, are you working under the assumption that it was the consumption of Earth's Best Baby Foods that caused Ethan to develop the cluster of diagnoses in your report?

A Well, there's a large outline of my summary of records which starts on Page 6. And then there's additional documents that I have reviewed that are also summarized later on in the report. I can pull up the specific page if you want that. And so those are the specific records I have reviewed, which do include lab tests.

And then talking with Dr. Sarah Palmquist,

32

the mother, along with other treating physicians in the medical record, I would say that it's clear to me, based upon the mother and the treating physicians, that there is heavy metal toxicity. But I am not opining directly on Earth's Best because I don't recall looking at specific things directly from that manufacturer.

Q Okay. And so with regard to -- we'll put Earth's Best aside. With regard to Ethan's diagnoses and metal toxicity, have you done an independent evaluation of Ethan's metal exposure to determine that he was exposed to sufficient levels of metals to cause his cluster of diagnoses listed in your report?

A Other than reviewing these records that we've outlined, I have not performed an independent evaluation of what you're describing.

Q Okay. And I may come back to that a little bit later today just to make sure -- just to make sure I understand the scope of what you've done. But is it fair to say you've taken what you learned from Dr. Palmquist and you've looked at the medical records from, say, like, you know, Dr. Megson or what have you, and based on those you've made a determination that Ethan suffers from metals toxicity, but you haven't undertaken an independent

33

analysis of his metal levels and his exposures and, you know, the very particulars of what metal might have caused the cluster of symptoms that you list in your report?

A So that would be one way to describe it, but it's also not including my review of additional records and lab studies and the examination of Ethan at his house. So those things need to be included. In addition to discussing with the mother, Dr. Sarah Palmquist, and the treating physician medical records as well.

Q Okay. And that's actually where I just was seeking some clarification. You've looked at Ethan's metal testing results, correct?

A That's correct.

Q And are you opining that based on those metal testing results, you believe that the levels reported in those results could be and, in fact, here are causative of heavy metals toxicity?

A Well, I think it's more than just one lab report. I think it, again, is the entire timeline of his development and regression, plus interview with the family and the mother and Ethan, plus the treating medical records -- excuse me, the treating providers and their medical records.

34

So using the totality of information, that's why I do have heavy metal toxicity in my Page 1 executive summary.

Q Are there any particular metal testing results that you believe are supportive of a finding of heavy metal toxicity?

A I would have to have those labs in front of me to -- to answer that question, Ms. Paley.

Q But off the top of your head, there's no particular results that stuck out?

A So I wasn't asked to do an independent review of the heavy metal toxicity or the lab reports on that. My job as a physiatrist and a physical medicine rehab specialist is very simple: Taking Ethan, with his diagnoses today and impairments, and then using my experience to predict within a reasonable degree of medical certainty his future care. And then the rest of the report ensues.

Q Okay. So is it fair to say your report was not focusing on a causation assessment. Your report was focusing on, Given where Ethan is now, here's the care I anticipate he might need?

A I think that's a good summary of my report.

Q In your -- in your regular practice, have

35

you ever diagnosed a patient with autism spectrum disorder?

A I have previously.

Q How many times?

A Typically, it's not just me as a physiatrist doing this. It would be -- like my experience at Dell Children's Hospital in Texas, working with geneticists, psychologists, neurologists and the physiatrist or PM&R doctor, also known an physiatrist. So in my four months of focused Dell Children's Hospital training, there was probably anywhere between five to ten that we diagnosed in those four months.

Q Okay. And that four months was a -- I'll try to get this phrasing right. Is that a rotation in your residency?

A So physical medicine and rehabilitation physicians are trained in pediatric rehab, diagnosis, treatment. And I also was trained in the neurology aspect and neurosurgical aspect. And so we have to do pediatric rotations as part of the residency. In my specific program, we had a dedicated Children's Hospital in Texas to do that; four months for that specific rotation.

Q Okay. And since that four-month rotation

36

during your residency, have you diagnosed any patients with autism spectrum disorder?

A I typically would refer to other pediatric specialists here locally in Denver. So I have not diagnosed since that timeframe.

Q Okay. And in your regular practice, have you ever diagnosed a patient with Crohn's disease?

A A similar type of situation where I might have it on my differential diagnosis but then would want to refer to a gastroenterologist. Because they would need to have an interventional procedure, like a colonoscopy or EGD upper endoscopy, to confirm or refute that specific diagnosis.

Q And how often does Crohn's come up in your work as an interventional orthobiologist -- biologicist?

A So I wouldn't use that term because that's just -- it's, number one, the term would be orthobiologics, in that we defined as the autologous blood, platelet-rich plasma or bone marrow. But my work is a physiatrist, physical medicine and rehabilitation. I have faculty appointments at both medical schools in town. I have hospital-based practice. I still see pediatrics in my clinic. Plus I do procedures.

37

It just so happens that the majority of my clinical research and clinical procedures are involving orthobiologics versus surgery or like hygo-steroid (phonetic) epidural for sciatica would be, you know, kind of an example.

Q So I can clarify the question. How often does Crohn's come up in your clinical work, more broadly?

A Yeah. So more broadly, we're managing patients, I'm treating patients that have this existing diagnosis or patients have other complaints other than their spine, orthopedic, neurological system that they're talking to me about. And I'll have to, then, refer to the GI doctor or gastroenterologist for those confirmatory studies. So it's pretty frequent.

I mean, different autoimmune diseases or autoimmune colitis or inflammatory bowel disease, I mean, I'm definitely seeing patients at least once a month that have that working diagnosis differential or an existing diagnosis already.

Q And do you care for -- do you -- strike that.

Do you care for patients with respect to their Crohn's specifically? Do you provide the

38

medical care to take care of their Crohn's disease?

A So when I have a patient admitted to an inpatient rehab unit, I'm a primary physician, which is full management, prescribing the medications. So if a patient comes in with this existing diagnosis, it's my responsibility to continue the medications, monitor the medications, monitor their symptoms while we're also doing whatever else they're admitted on inpatient rehab unit for. So in that regard, yes.

In the regard of doing colonoscopies and EGD, no, I don't perform those types of gastrointestinal procedures.

Q Okay. So apart from the inpatient setting where you're managing patients on their current regimen of medications --

A Uh-huh.

Q -- while you perform, you know, other interventions, apart from that do you provide -- you know, it sounds like -- am I correct to say you don't provide day-to-day care for Crohn's patients with respect to caring for their actual Crohn's disease?

A That would -- that would, again, be a very broad summary. Because, really, no physician or healthcare provider will provide day-to-day care for any patient with inflammatory bowel disease. But

39

yes, at times, right, I have to prescribe things in the hospital, or even in my outpatient clinic. Some patients do need steroids packs for a flare, and so that has been something I've done. But, again, I'm not a gastroenterologist that's performing the colonoscopy to confirm or refute a diagnosis of inflammatory bowel disease.

Q Okay. And similarly with autism, in your clinical practice, although you may see patients who have autism, is it correct that you're not providing the day-to-day care and management of their autism spectrum disorder?

A Yes, with the same kind of global summary -- that would be a simplified summary. It's not day-to-day care. That would be a correct statement.

Q Okay. And in your regular practice, have you ever determined the etiology of a patient's autism?

A Not since my residency training and time spent at Dell Children's in Texas.

Q And that was a four-month period during residency, correct?

A That's correct.

Q And during that four-month period in

40

residency, did you determine the etiology of patients' autism spectrum disorder?

A So I think I kind of alluded to that earlier about the comprehensive collaboration between multiple specialists, neurologists, general pediatricians, pediatric developmental specialists, the geneticist Ph.D., the neurologist and the PM&R doctor. And so we had kind of like a comprehensive clinic where the children would come in and have evaluations from all those different specialties.

So me, personally, it was not my specific role to undertake the etiology of a spectrum or constellation of symptoms or syndrome that we can refer to as autism.

Q So others may have done that sort of etiological evaluation during your residency, but it wasn't your personal role to do so; is that correct?

A As the physiatrists, we're working together and identifying the functional improvement, medication management, procedural intervention for that patient with autism for the remainder of their life, starting, you know, whatever age they are, even into adulthood. So that would be the main role of our specialty, physical medicine and rehabilitation.

Q So it's not personally your specific role

41

to undertake the etiological evaluation, correct?
A That's correct.
Q Okay. And similarly for Crohn's -- maybe we can sort of sort-circuit this. In your day-to-day work -- I want to get this phrasing right -- is it your role personally to undertake an etiological evaluation of a patient's Crohn's disease?
A I would refer to the gastroenterologist. So it's not in my day-to-day workflow.
Q Okay. And in the course of your practice, have you ever determined that the ingestion of metals caused any injury to a patient of yours?
A I -- I'm not recalling a specific patient at this time --
Q Okay.
A -- in my day-to-day practice.
Q All right. I'm just looking at my outline because I may be able to skip a few questions. I want to be --
MR. PARKER: That's wonderful.
Q (BY MS. PALEY) -- respectful of your time.
MR. PARKER: Wonderful. Thank you.
Q (BY MS. PALEY) All right. So, Doctor, just so I understand, again, the scope of your opinions, are you opining that exposure to any

42

specific metals caused Ethan to develop autism?
A I'm not opining on those specific metals, and I don't think I have that documented in my life care plan either.
Q Okay. And similarly for Crohn's disease, are you opining -- opining that exposure to any specific metals caused Ethan's Crohn's disease?
A I also did not put that in my life care plan, and I am not opining on that question either.
Q Okay. And as for any of the other diagnoses that you list in your life care plan -- I don't have the page in front of me, but I think there are 12 or 14 diagnoses, something like that, are you opining that exposure to any specific metals caused any of those diagnoses?
A Can you just give me one second please?
Q Yeah. And I'm trying to find the page so I can point you to it. Page 63 and 64, Diagnostic Conditions 1 through 13. And I'll just let you take a look at that and then I'll re-ask the question.
A Yes, please. What was the question?
Q Okay. Are you opining that exposure to any specific metals caused -- strike that.
Are you opining that exposure to metals caused Ethan to develop any of these specific

43

diagnostic conditions you list in 1 through 13?
MR. PARKER: Object as to form.
A So I think we -- we basically touched on this already. Based upon my review of the history, medical records, treating physicians, which did include lab reports, it is my opinion, consistent with other physicians', that heavy metals did have a role in his neurocognitive disorder. And so that is similar to other neurocognitive disorders caused from other types of injuries; lack of oxygen, tumors, trauma, et cetera.
And so Section 4.1, my 13 diagnostic conditions, in my opinion, are related to that and that's why I have them listed here.
Q (BY MS. PALEY) And so two questions coming from that.
A Uh-huh.
Q Is -- do you believe that the science shows that metal exposure causes autism specifically? Not neuro -- not a range of neurocognitive disorders, but autism specifically?
A So I think --
MR. PARKER: Excuse me. You've got to slow down. Give me time to object.
THE DEPONENT: Yep.

44

MR. PARKER: I'm an old southern boy. That's all I ask.
Object as to form.
A What was the question, Ms. Paley?
Q (BY MS. PALEY) Do you believe that metal exposure causes autism specifically? Not a range of neurocognitive disorders more broadly, but autism specifically?
MR. PARKER: Again, I object as to form.
A So I hear the question as, does metal exposure cause autism specifically. Is that correct?
Q (BY MS. PALEY) Correct.
A Well, I haven't been asked to opine upon that. And my role here is, again, understand his current functional situation, diagnoses and his future rehabilitation needs and medical care. I --
Q Okay. Sorry. I didn't mean to cut you off. It was more of a reflexive "okay."
A So I don't have an opinion on that statement. I wasn't asked to do that. I'm not prepared to answer that question.
Q Okay. And so you haven't undertaken any assessment to rule out other potential causes of autism in this case; is that correct?
A Can you help me understand what you mean

45

by potential assessments?
Q Have you undertaken any analysis to rule out like a -- the term is not differential diagnosis, because that's not what we're talking about. But have you taken any -- have you undertaken any analyses to rule out other potential causes of Ethan's autism? I'm guessing that's no, if you're not opining on the cause of autism, but I just want to be clear.
A So to be clear, I'm not a treating physician for Mr. Ethan Palmquist. So I wouldn't have diagnostic tests and things to identify etiology, differential diagnoses. I am the PM&R physician to, again, identify current diagnoses and then future medical care.
Q Okay. But you did receive his medical records in this case, right?
A That would be outlined in my report. Yes, ma'am.
Q Okay. And based on your review of those medical records, you didn't undertake an analysis that would rule out other potential causes of autism; is that correct?
A I just don't still understand exactly what you mean by "undertake an analysis," Ms. Paley.

46

Q Did you do any work of any kind to rule out other potential causes of Ethan's autism?
A I think I answered the question, because that's not my role. I'm not a treating provider. And the work undertaken is the entire publication of the life care plan.
Q And are you opining -- I might have asked this, and if I did, I apologize. I really genuinely don't recall.
Are you opining that exposure to metals caused Ethan's Crohn's disease?
MR. PARKER: Form. It was asked and answered.
MS. PALEY: Okay. Thank you. I genuinely did not remember.
Q (BY MS. PALEY) With apologies, can you remind me of your answer, just so we don't have to go back through the record?
A So, again, based upon the treating physicians, where I reviewed their medical records, and understanding the history and temporal sequence or time line of events, that -- that statement or question is probable that that contributed to his development of Crohn's disease. And that's why I have contributed care and that diagnosis for Crohn's

47

disease in my life care plan based upon those treating physicians and their existing medical records.
Q And so your analysis as to the cause of Ethan's Crohn's disease is based on what you see in the medical records but not based on any broader review of the literature and whether metal exposure causes Crohn's disease; is that correct?
A The medical record review would document that metal cause of Crohn's, when I did speak to the treating gastroenterologist, Dr. Krigsman, that was of his opinion.
And then I think your last question was a literature review. And I was not asked to do a literature review specifically in this case, to answer that last question.
Q Okay. And so -- all right. You weren't asked to do a literature review; therefore, you -- just to be clear, you haven't undertaken a literature review regarding any association between metal exposure and Crohn's; is that right?
A That's correct.
Q And have you ruled out all other potential causes of Ethan's Crohn's disease?
MR. PARKER: Objection as to form, asked

48

and answered.
A I think, again, you know, I don't -- I don't rule out things, because I'm not a treating physician. We don't establish a treating physician/patient relationship and a therapeutic relationship with either the family or Ethan because he's a minor. That's not my role.
And so based upon my review of this detailed medical summary, the other treating physicians, in my opinion, did do what you're asking: They evaluated other causes of Crohn's disease.
Q (BY MS. PALEY) And when you say "based upon my review of this detailed medical summary" --
A Uh-huh.
Q -- who drafted the detailed medical summary in your report?
A That would be both myself and my team at Physician Life Care Planning.
Q Okay. And so does the team at Physician Life Care Planning undertake the first draft of the medical summary and you review and edit from there? I just want to understand the process.
A Yeah. As we discussed earlier, the process is all the records are uploaded and I have them in a HIPAA-compliant -- so I can review them.

49

And I'm reviewing them. And I have specific staff trained in what I ask them to do, specific location of care, date of care, providers, diagnoses, treatment plan, diagnostic studies.

And so with that, then they're able to kind of give me an outline. And then from there, both my staff and I are creating the actual words on the paper of the specific summary per each medical encounter.

Q And did you train that staff or did Physician Life Care Planning train that staff?

A It's a little bit of both, because this is my life care plan and I have reviewed all the pages and authored them. And I have discussions over phone with the staff on specifically what I'm looking for, or at times I need to change it myself. And then they also are trained via Physician Life Care Planning directly with the onboarding process, is what I was told. I'm not involved in the hiring or onboarding process.

Q Understood. Have you reviewed all of the medical records in this case or at least have -- strike that.

Have you reviewed all of the medical records that you received in this case?

50

A So all of the medical records that I summarize initially -- and then if you would just give me one second -- I do have that other page we alluded to, which included other documents, which starts on Page 53, Section 2.3. I have reviewed all of those medical records and -- and the list of other documents on Page 53 and 54 personally.

Q Okay. And do you have an estimate as to about how much time you spent reviewing those medical records and the other documents listed on Pages 53 to 54 of your report?

A Yes. My best estimate is between 30 and 35 hours on reading thousands of pages of what we're describing; the full medical records and these additional other documents.

Q Okay. And I'm going to ask about a few categories of materials. I don't -- I don't think I see them listed in your documents, but I just want to understand if I missed anything.

A Okay.

Q So did you review any documentation demonstrating the metal concentrations in Earth's Best Baby Food? I don't think I see it listed, but I just want to be clear.

A Yeah. Thank you for an opportunity to clarify. Can you help me understand exactly what you're asking me one more time, please.

51

Q Yeah. Have you reviewed any documents from any source that provide testing data showing the concentrations of metals in Earth's Best Baby Food?

A Just so I understand, you're not asking if I've had the lab reports from Ethan. You're asking if there's lab reports just from the food; is that correct?

Q Well, I'll name a couple potential sources of materials.

A Okay.

Q Have you reviewed a congressional subcommittee report that reported on the levels of metals in baby foods from Earth's Best and other manufacturers?

A I do not recall reviewing that report.

Q Okay. And have you reviewed a report by an organization called Healthy Babies Bright Futures that included an appendix that had metal levels in Earth's Best and other manufacturers' baby foods?

A I do not recall receiving that review and that report.

Q Okay. Did you review any literature addressing metals toxicology?

52

A Do you mean documents provided or peer-reviewed literature?

Q Peer-reviewed literature.

A Not specifically for this case. I have, in my career, come across different things for acquired brain injuries and encephalopathy for heavy metal toxicity.

Q But did you refresh your review of any of those materials as part of your work in this case?

A I was not asked to do that. So I did not do any minor or extensive literature search or PubMed or National Library of Medicine search in this case.

THE REPORTER: Or National?

THE DEPONENT: I'm sorry. National Library of Medicine and PubMed. Thank you.

Q (BY MS. PALEY) And did you review any literature -- which I mean like peer-reviewed, published literature -- addressing the epidemiology of metals exposure, whether related to autism or otherwise?

A I did not in this case.

Q Okay. And did you review any literature addressing the causes of autism?

A In this case, I did not.

Q Okay. Did you review any literature or

53

any -- strike that.
Did you review any literature or treatment guidelines addressing current practices in treating autism?
A I think when I was reviewing some of the treating physician documents, I likely did do a quick Google search on an update or maybe even up-to-date website. I don't recall those specifics. That would have been probably mid-March timeframe. Probably less than 20 minutes I spent doing that. That was not a specific guideline from like the American Academy of Pediatrics, per se.
Q Okay. Thank you.
MR. PARKER: Is this a good breaking point?
MS. PALEY: Actually, yeah. Let me -- give me five seconds.
MR. PARKER: Sure. Sure.
MS. PALEY: Yeah. It's a good breaking point. Let's do that.
MR. PARKER: And we'll make it quick so you can -- no hurry. I'm recommending --
THE REPORTER: Excuse me --
MR. PARKER: -- you walk around to your --
THE REPORTER: Excuse me. We have to go

54

off the record.
THE VIDEOGRAPHER: The time is 9:10. We're off the record.
(Recess from 9:10 a.m. to 9:23 a.m.)
THE VIDEOGRAPHER: The time is 9:22. We're back on the record.
Q (BY MS. PALEY) Okay. Welcome back, Doctor. Let's talk a little bit about your examination of Ethan.
I understand that around March 10th or so, you had a video chat with Dr. Palmquist; is that correct?
A Specifically his mother, Dr. Sarah, that's correct.
Q Okay. And about how long did that video chat last?
A I think that was anywhere probably between 75 and 85 or 90 minutes.
Q Okay. And what did you cover during the course of that video discussion? It can be high level at this point.
A High level is the general history from birth up until about May 2017, which I kind of summarize here on Page 55. And then past that, the specific changes in his function, speech, behavior,

55

medical treatment, medical tests, medication prescriptions, things like his EEG, hospital admissions, spinal tap, everything that the treating providers were doing to work him up as well as treat him.
Q Was Ethan involved in that video chat at all?
A Ethan I don't think has the ability to participate in that type of chat. So initially the one-on-one, Dr. Sarah Palmquist and I, it was just us. Ethan was not involved.
Q And then do I understand it correctly that on March 14th, you had an in-person visit of about 90 minutes with the Palmquists?
A Yeah, a little bit more than 90 minutes at their house. But it was 90 minutes of kind of one-on-one. I don't want to use the term chasing Ethan around the house, but essentially I was following him to observe him, attempting some observations, exams, and then also kind of clarifying with the father, Grant, Mr. Palmquist. And that's also when I was able to see the two little sisters as well as the maternal grandmother at their house in Pearland, Texas.
Q And when you say "clarifying with the

56

father, Grant," what do you mean by that?
A Because I didn't have the opportunity to speak with him previously in that week prior. So "clarify" as in, Well, Grant, how are things going? How is the activities of daily living? How are you dealing with your son? How is this affecting, you know, the life with the two daughters, et cetera.
So reporting on his perspective in addition to mother, Dr. Sarah's, perspective.
Q And from your description, I assume that Ethan is ambulatory?
A That's correct.
Q And does he require any complicated feeding procedures?
A So I think I did put a little bit of that in my exam. He -- he's unable to prepare food and a hundred percent feed himself independent. And he obviously can't clean up food.
He also has to be supervised because he will eat nonorganic things at times. And so that's been reported by the family, and I did see him eat some dirt as well when I was at their house.
Q What assistance does he need with feeding itself? I understand not preparing or cleaning up, but with feeding itself.

57

A So the only thing that I observed that he was able to do was essentially lick peanut butter off of a spoon, in a direct observation. I wasn't there at the dinner or kind of lunchtime. I was kind of in the middle afternoon time. So I don't have a direct observation of that, but I have the report from his mom about the setup, supervision. At times, he does have to be fed. At times, he can take things and shove them into his mouth.

So that would be a kind of supervision with setup, minimal assistance is how I would describe that --

Q Okay.

A -- for Ethan physically getting safe food, real food in his mouth.

Q And there were no concerns about him choking on peanut butter? Licking from the spoon? Anything like that?

A During my observation of the peanut butter, I did not have any concerns of him choking on peanut butter at that time.

Q Okay. And just to make sure I understand, you haven't provided Ethan with any medical treatment, right?

A That is correct. We have not established

58

that treating patient/provider relationship.

Q And you don't intend to establish a treating patient/provider relationship; is that correct?

A That's correct.

Q Okay. Just for a matter of clarification, so I understand, if we could look at Exhibit 5. Exhibit 5 is the collection of -- let's -- first the list of materials received and then the collection of invoices. I just have a couple questions from there.

A Sure.

Q If you look at -- there's some like Bates numbers on the bottom right side. If you look at Page 2531, it's an invoice dated March 11th, 2022. It looks like you had an IME on the 14th of March; is that correct?

A That's what the invoice states, and that's what we were just discussing with the home visit, face-to-face visit with Ethan and his family on March 14th, 2022.

Q Okay. And then if you look at the prior page, Page 2530.

A Uh-huh.

Q The invoice date is about a month earlier. It's February 16th. But it lists a second IME on the

59

same date as the first. And I just want to make sure I understand what happened. Did you conduct two IMEs, independent medical evaluations?

A So I can explain, I guess, this page and initially also the utilizing Page 002529. On the Page 2529, on the initial life care plan, that includes the initial examination. This specific instance, it was the one-on-one call with the mother.

Q Okay.

A Moving to the next page, 2530, we do charge for any repeat examinations. In this case, it is IME. And it's just labeled as second, not to denote there was two separate face-to-face visits, but it was second because the first contact was the direct call with Dr. Sarah.

And then the following page, on 2531, those invoices are just denoting travel from -- obviously out of my office, not seeing patients in the hospital or doing procedures, the cost of travel to Houston.

Q Okay. So I didn't miss a second in-person examination of Ethan or anything?

A That's correct.

Q And then I believe you noted in your report that you had some follow-up with Dr. Palmquist

60

around March 23rd or so. That's on Page 55 of your report, I believe it is.

A Yes.

Q Okay. On -- yeah. Paragraph, introduction, I had the opportunity to speak with Dr. Sarah Palmquist on March 23rd when she identified he was plateauing without progress.

How long was that call on March 23rd? Or was that a call, I should actually ask.

A It was just kind of a direct cell phone to cell phone. That was about 2 to 3 minutes. Basically everything else is the same other than what I dictated here, changes in the ABA. And she told me that he won't have that option as of June 2022. And that was it.

Q And have you had any other contact with Dr. Palmquist apart from what we've discussed here?

A No, ma'am.

Q Okay. Any -- just to make sure I'm being thorough, any emails, texts, any kind of written communication from Dr. Palmquist?

A No. I don't feel that would be appropriate at this time, to continue that. It would need to be a full evaluation to amend or supplement my report.

61

Q Have you learned since March 23rd that Ethan was dismissed from the ABA program?
A I think it's what I have here on Page 55, where the mother, Dr. Sarah, was telling me he was going to be. But I have not had the mother tell me since then that that actually occurred, because we have not spoken since March 23rd.
Q Okay. So from Dr. Palmquist or from any other source, no updated information on Ethan's dismissal from the ABA program; is that correct?
A I believe that's correct.
Q And do you have any experience with patients in ABA? Do you recommend patients being like put in ABA programs?
A So back in Texas, yes. More recently in Colorado, no.
Q And back in Texas, was that during the four-month rotation during the residency?
A That, and then occasionally we would see somebody in our outpatient clinic, meaning like the University of Texas PM&R outpatient resident clinic. And so at times, I'm sure that came up. I can't recall a specific instance. I'm trying to remember 2013, 2014, 2015, et cetera.
Q Okay. Well, now since we have Exhibit 5

62

out in front of us, can you turn to the next page, 2532. And this is a March 21st, 2022, invoice from Physician Life Care Planning to Arnold & Itkin.
A I'm sorry, which page?
Q 2532. And I'll wait for you to get there.
A I'm there. Thank you.
Q Okay. And I understand, based on this invoice that you spoke with two of Ethan's treating physicians; is that correct?
A That's correct, yeah.
Q Okay. Total time was about 45 minutes; is that right?
A Yes.
Q Okay. And let's talk about your conversation with Dr. Krigsman. You spoke with Dr. Krigsman for about 15 minutes; is that right?
A Roughly, give or take.
Q I see the invoice date is the 21st of March. Do you know when you actually spoke with him?
A It might have been that day or one to three day -- one to three days prior. I don't recall specifically the day, but it likely was surrounding that timeframe, March 21.
Q Okay. That's some efficient invoicing. I will give credit to whoever takes care of the

63

invoicing.
Now, Dr. Krigsman treats Ethan for GI issues; is that right?
A Yes. It's my understanding he's a gastroenterologist.
Q Does he provide any other medical treatment to Ethan beyond gastrointestinal issues?
A I would have to re-review his last one or two notes to fully answer that completely.
Q Are you aware of -- like does he provide Ethan with treatment for neurological issues?
A Typically not --
Q Okay.
A -- per my memory on my medical record review.
Q And does Dr. Krigsman treat Ethan for his autism specifically?
A I don't recall reviewing that specifically either.
Q And out of all of Ethan's providers, how did you decide to contact Dr. Krigsman specifically?
A That's a good question. So because Dr. Krigsman performed the types of scope tests and is prescribing the specific medicine for Crohn's disease and, as you alluded to, I'm not daily

64

managing Crohn's disease and prescribing these patients steroids or HUMIRA type of treatments or doing colonoscopies. We do -- I do, and physician life care planners, call treating physicians at times.
So specifically I had a few questions for him, which I outlined on Page 55. And that was the reason why I wanted to reach out to the gastroenterologist, to make sure that I understood what he was thinking and his recommendations.
Q So I see the paragraph that you're referring to on Page 55.
A Yeah.
Q Introduction, Section 3.1. And are you referring to the last sentence of that paragraph?
A Yes, ma'am.
Q Okay. And did Dr. Krigsman comment on Ethan's need for antiseizure medication?
A That would be the -- Dr. Rotenberg, neurologist, on the antiseizure medications.
Q And did Dr. Krigsman provide comment on Ethan's need for supervision?
A Yes. My recollection and my documentation is Dr. Krigsman, normal life expectancy, lifelong care, lifelong Crohn's disease and supervision.

65

Q And did Dr. Krigsman specifically review the care recommendations in your report?
A No, ma'am. Because my report was finalized and published March 30th, and we had our phone call before that completion date.
Q Did he review the care recommendations in any draft version of your report?
A I never sent him a draft version, but that would be really a question for him and/or counsel, if they had received my report, because I do not know.
Q Okay. So --
MR. PARKER: We didn't send anybody anything.
MS. PALEY: I don't understand. I'm sorry.
MR. PARKER: I assure you we did not send it to him.
MS. PALEY: Okay. Thank you. Thank you.
Q (BY MS. PALEY) And so if Dr. Krigsman didn't receive a draft version of the report, is it safe to say he didn't review and provide comments specifically on the frequency and duration of the recommended care in your report?
A No. I think that's incorrect. I wouldn't agree with that.

66

Q Well, how -- how did he provide commentary on the frequency and care -- frequency and duration of the recommended care in your report if he -- if he didn't see the report?
A Sure. So that, again, is part of me being a physician, understanding the medication dosing, frequency and duration. So moving to answer this question, a few pages forward to Page 59, and looking at the three main medications that Dr. Krigsman is prescribing, HUMIRA. Numbered next is the Pentasa. Numbered next is Entocort.
Q Okay. And did Dr. Krigsman provide commentary on your recommendations regarding the frequency and duration of HUMIRA, Pentasa and Entocort recommendations in your report?
A That's a great question, and definitely getting there to answer the question. Because the current prescriptions and frequency and dosing were available to me from medical record review and the medication regimen from Dr. Sarah Palmquist, we discussed that on the phone, which is what's outlined on Section 310.
Moving then into my specific recommendations on the medication side, they are the same dosing, duration, frequency that Dr. Krigsman

67

recommended when I spoke to him and what he currently is prescribing for Ethan. So it's consistent from that current dose to what I have recommended in my life care plan.
Q And regarding duration, did you specifically discuss the idea of essentially lifelong treatments with HUMIRA, Pentasa and Entocort?
A Specifically, Dr. Krigsman and I first -- Do you expect him to have a normal life expectancy? Yes, given the treatment. Okay. Then do we have the anticipation, from your GI subspecialty, all medicines will be for that duration of life? Yes.
And that's why I document that on Page 55 and have my medication treatment per the methodology for the remainder of Ethan's life expectancy.
Q Now, I notice if we look back on Page 55, that last sentence that we were talking about, you note that, Both treating physicians agreed that we expect to have -- that we expect Ethan to have a normal life expectancy, will need lifelong care, lifelong antiseizure medicine, lifelong Crohn's disease medicine, among lifelong supervision and other care outlined in my report.
And here's my question. Are -- what other care outlined in your report did you specifically

68

speak with Dr. Krigsman about?
A Yeah. Those were the basic essential service -- excuse me, not essential services, like DME things regarding his bowel/bladder habits, and the follow-up visits, which also include like the colonoscopy procedure, office visits from a pediatric GI specialist, Dr. Krigsman, and then transitioning to an adult GI specialist. And then all of these are in Section 5.
Q Okay. And so when you spoke with Dr. Krigsman, he was only commenting on sort of the GI-related issues that you recommended in your report. He was not commenting on things like the neurological issues or specific therapies that were recommended for Ethan by you, anything like that?
I just want to understand, was he commenting within the scope of his expertise as a GI? Or did he provide a broader assessment of what is outlined in your life care plan?
A Can you just repeat the last part of your question, please. That was a long one.
Q It was. And I apologize for that. That kind of evolved as it went along.
Did Dr. Krigsman comment on your report within the scope of his expertise as a GI or, more

69

broadly, on all the care outlined in your report?
A Okay. So he didn't comment on my report because I did not send it to him. As far as I know, Physician Life Care Planning and counsel did not send it to him. So I think that was your first question.
Second question, GI scope of practice is what he commented on. However, I did tell him my suggestions on the counseling, the therapy, home health aides. And I don't recall any disagreement with that. Instead of being redundant and wordy -- because it already is long -- I sort of summarized that on Page 55, the way that I dictated it, because it's clear to me what that means.
I'm happy to continue to explain that.
Q Okay. And just understand, this call with him was about 15 minutes?
A Yes, ma'am.
Q So I take it you couldn't get into any great detail about the, you know, frequency of care you were recommending regarding counseling, therapy, health aides, things like that?
A 15 minutes is a lot of time for a doctor-to-doctor, peer-to-peer discussion, actually, because we are not talking about our kids and the weather and how hot it was and the airplanes or all

70

this stuff that we've been side-talking about. It is straight objective. And this is my role as a PM&R doctor, and I am doing his future medical care, and I have these four pertinent questions for you. He answered them as we discussed. And then I made the suggestions that I need some increased therapy and daily home health aides. Okay. Great. Sounds reasonable. And that was it.
Q Okay. Any more detail on that increased therapy? I mean, I just want to know, did you talk about the very specifics of the recommendations or the concept of having home health aides, various therapies?
A Global concept is more how I would describe it, not the specific duration, frequency, timeframe, hours of multitude of therapeutic interventions or the specific home health aides.
Q Okay. That's very helpful. That's all I was getting at. I'm sorry it took me so long to get to it.
Did you -- strike that.
Did you know that Dr. Krigsman is known for his controversial research that has claimed that the MMR vaccine causes autism?
A I mean, I'm not familiar with how you

71

would describe "controversial" or his specific research publications. I do know that he is a published physician researcher, like myself, in his specific specialty. And we were not discussing his independent research when we had that conversation. We were, again, being objective, getting to the point on the questions at hand on specific Crohn's disease management.
Q Were you aware of Dr. Krigsman's research on MMR vaccines and autism?
A I might have seen it on his website in passing or in passing or something, but I have never read abstracts or full papers on it.
Q And do you believe that the MMR vaccine or any components of the vaccine cause autism?
A Well, I'm not prepared to answer that question at this time, because I haven't researched, prepared for that. So I wasn't asked to do that. So right now, you know, I can't opine on that.
Q Okay. Do you believe that it's generally accepted in the medical community that MMR vaccines or any components of them cause autism?
A That's a hard question, because how do you define the medical community, number one. And all physicians have slightly different baseline training

72

and specialty. Some physicians may or may not have kids. Some physicians may have autoimmune disease in their family, and maybe they have a complication or family member that might skew their perspective.
And so without a consensus statement from the AMA or a specific American Academy of Pediatrics statement, I don't have any opinion or reference to answer your question.
Q Okay. So you're going to just kind of punt on that one?
A I cannot answer that. I don't have an opinion on that one right now.
Q Okay. Did Dr. Krigsman's research have any influence into your -- sort of how you weighed his comments on the life care plan recommendations?
A So, again, I did not read any specific research from him. Therefore, it is unable -- his research -- to have weight on my opinions for my document, catastrophic life care plan. It is consistent that I've seen in pediatric patients with this type of diagnosis transition to adults, as well as adults that need lifelong care with these types of medications. So that is consistent with my scope of practice and my knowledge of this type of disease.
But, again, there is no specific research

73

we discussed or I reviewed that had any weight or input in my life care plan.

Q Okay. And as I understand it, you sort of maybe haven't read his specific articles but have a general sense of maybe the area and leanings of his research. I just want to know, did --

MR. PARKER: Objections. I'm sorry. Finish your question.

Q (BY MS. PALEY) Okay. My question is just, did your general knowledge of his research and leanings in that area, did that have any influence? Was it in any way a toggle in terms of how you evaluated his response to the recommendations that you discussed with him?

MR. PARKER: Objection as to form, mainly as to the commentary before the question.

THE VIDEOGRAPHER: Pardon me. This is the videographer. Sir, if you're going to have your mic off -- which is okay -- can you speak up?

MR. PARKER: Objection as to form, mainly as to the commentary right before the question.

A I'm sorry, what was the question?

Q (BY MS. PALEY) Did your general knowledge of his research and leanings have any influence in the way that you evaluated his response to your

74

recommendations in the life care plan during your discussion with him?

A I think I answered that last time. And so, again, given my understanding of lifelong care for these diagnoses and his response of, He needs lifelong care and medication for these, that first part is no.

The second part is that when physicians are published or doing ongoing research in their area of expertise, gastroenterology, the only thing that I could say is that that bolsters that physician's experience and opinions regarding specific diagnoses, because not only are they treating them, but they're also actively engaging in research surrounding those diagnoses.

No research from Dr. Krigsman has been reviewed by myself; and, therefore, again, it's not contributing to my opinions in my life care plan.

Q Does research bolster the physician's experience and opinions even if that research has been discredited?

MR. PARKER: Objection as to form.

A You know, I can't necessarily answer that, because clearly there's differences of opinions today, in this room. There's differences of opinions

75

between different physicians. It happens all the time. And so unless there's everything lined up in front of me with specific abstracts and research papers and letter to the editors and commentary and rebuttals, I have no basis of information to answer your question.

Q (BY MS. PALEY) Okay. Now, you spoke with Dr. Rotenberg for about 30 minutes, right?

A Yes, ma'am.

Q And to the best of your knowledge, did Dr. Rotenberg have any role in Ethan's care before the initiation of this lawsuit?

A I'm not sure how to answer that question because I don't think I know the date of the initiation of the lawsuit. I don't even know exactly what that legal term means of what you're telling me.

Q Fair enough. That's okay.

Were you aware that counsel in this case actually introduced Dr. Rotenberg to the Palmquists?

A I don't recall reading that or being told that. So I don't know if that's speculation or fact.

Q Okay. So you just don't know one way or the other? It wasn't -- I'll strike that. There's no question there. It's okay.

A Okay.

76

Q How did you specifically choose to speak with Dr. Rotenberg regarding your recommendations for Ethan's life care plan?

A Well, the similar, you know, concept of what we discussed with the GI doctor. Because there's neurological diagnosis, neurological medications and future neurological care that has been discussed. So speaking directly to the pediatric neurologist allows me, then, to go through the similar line of questioning -- life expectancy, duration of care, specific medications, testing, et cetera -- and then sort of the details surrounding the antiepileptic medications or seizure medications.

Q Okay. And just to maybe short-circuit this a little bit. We talked about the process that you used in discussing your recommendations with Dr. Krigsman. Was that essentially the same process that you used in discussing your recommendations with Dr. Rotenberg, just a slightly different focus, neuro versus GI?

A Generally speaking, that was, you know, very similar, a little bit more time spent because there was a little bit more involved on the neurological aspect. And we -- we, as physical medicine and rehabilitation physicians, are speaking

77

to urologists and neurosurgeons frequently. And so there's a lot of specifics on things I have in my medical plan that I wanted to make sure that a treating physician would agree with my recommendations moving forward. And those neurological ones are slightly more involved than his GI symptoms and GI treatment.

Q And to the extent that you discussed recommendations for Ethan's various therapies, home health aides, educational programs with Dr. Rotenberg, did you discuss those at the same -- I think you may have used the term life -- global level as you did with Dr. Krigsman?

A I think with -- with Dr. Rotenberg, I discussed slightly more in the sense of this is, again, my role as a PM&R doctor. These are my four objectives in the life care plan. Let's review current treatment. Those next questions, and then a little bit more in detail on specifics regarding home healthcare aides, supervision, things like the Avondale House or adult group home house.

But it's not in detail as of it starts at this age, it's once a day, once a month for this duration for life. That detail was -- was not discussed with Dr. Rotenberg.

78

Q Okay. Thank you.

I also see if we flip -- I'm trying to look for the page. You had a brief joint conference with Drs. Nelson and Settles; is that correct?

A Yes, ma'am.

Q And that's on Page 2533. Now, you spoke with these experts jointly, correct?

A Referring to jointly as all three of us were on the same conference call?

Q Correct.

A That's what we did. Correct.

Q All right. And how did you decide to speak to Drs. Nelson and Settles specifically?

A That information was because I'm a retained expert offering my opinion in this case regarding the future medical care and then the cost of that, which is essentially what my life care plan is, right?

Q Uh-huh.

A And they have a different skill set than I have.

Q And did they review a draft of your life care plan?

A No, ma'am. The date here, we have about March 22nd. And that could have been the date I submitted billing or the date we spoke on the phone. Regardless of that detail, it was within, you know, again, one or so days of March 22nd, 2022. And this was, Okay, these are my thoughts, an introduction of myself and what I do and my experience. These are my thoughts. These are what I have on my thoughts and my recommendations. And what are your thoughts? Because they, again, have a slightly different skill set than I have, given their education and training.

79

Q How would you describe their slightly different skill sets?

A Well, it's my understanding that Dr. Nelson is an MD, Ph.D. and he is board certified in I think pediatrics and pediatric neurology. And then Dr. Settles is a doctor of psychology -- I hope I didn't say that wrong. And so she has a slightly different skill set to evaluate a patient's intelligence and function, executive, memory and behavior that's outside of sort of medical physicians evaluating diagnoses and treatment plans and risk benefits of said treatment plans.

Q Did you ever see drafts of their expert reports?

A I have never seen a draft of their expert reports.

80

Q Okay. And why did you have this call jointly rather than individually with each of them?

A It's my understanding that they're both faculty I think at Tulane and their geographically similar area. We had approximately one week from -- you know, I was in -- I'm sorry, let me think about this. March 14th, I was at their home. Come back to Colorado. I have my busy medical practice, and we're having phone calls after clinic at like 5:30, 6 p.m. Mountain Time. And then eight days later after March 22nd was the completion of the report.

And so I think it was simply scheduling, because I'm very, very busy in my clinical practice. And that likely was the only time that all three of us could get together in that week timeframe that I had to get information to complete my report.

Q Okay. And you said that you shared your thoughts and recommendations and asked for their sort of feedback on that. What feedback did they give to you during that conference call?

A I'm sorry to jump on that.

But -- so not necessarily feedback but, you know, These are my thoughts. What are your thoughts? And so Yeah, those are great plans, and then, These are our thoughts. And then we were

81

basically saying the same thing from a neurological, medical perspective, Dr. Nelson; behavioral, supervision, intelligence, language, Dr. Settles's perspective. And then that's what led for me to have my more likely than not, medically reasonable recommendations outlined here in the life care plan.

Q And similarly to your calls with Drs. Krigsman and Rotenberg, when you discussed those -- you know, those therapies, those treatments, those, you know, home health aides, things like that, schools, with Drs. Nelson and Settles, was it also at a level that did not include this duration, this many days per week, you know, this sort of frequency and duration, nitty-gritty details?

A No, I think that's incorrect, because I'm understanding your question if Dr. Nelson/Settles conversation was consistent with treating providers, and it was slightly different. We did get more details, especially with Dr. Settles, regarding more frequency, intensity of some of the behavioral things, the home health aides, the supervisions.

You know, I had -- at this time recall explaining to Dr. Settles about the Avondale House I learned about and that being a preference for the family. And that was something that she was in

82

agreement with. And then just looking at my Page 72 and 74 on some of these other recommendations regarding rehabilitation services and nursing attendant care, post acute day, neuro program, special needs school, augmentative communication device with the software and iPad, even essential services and home modifications for safety, nursing attendant care, we did talk in more detail regard those specifics for Mr. Ethan Palmquist.

Q Okay. And they are -- they're also compensated expert witnesses in this case, right?

A I guess you would have to ask them that or counsel. I mean, I don't know. We don't talk about those things.

Q Well, they're not treating physicians. Can you agree to that?

A It's my understanding that they currently are not treating physicians.

Q Okay. In preparing your life care plan, did you speak with Ethan's current pediatrician, I believe it's Dr. Mohammad Albitar?

A I reviewed his medical records and did not see a need to speak to him, given my education, experience, skill set, along with specifically speaking with the specialists who are more managing

83

and prescribing those specific GI and neurological medications, et cetera.

Q Did you speak with Dr. Michael Watkins, a neurologist who's provided care for Ethan?

A No, ma'am, I did not.

Q Did you speak with Dr. Monica Proud, also a neurologist who's provided care for Ethan?

A I did not.

Q Dr. Nikogosian?

A I recall reviewing his records, but I did not speak to him. Again, similar manner, I was able to intake the information needed, garner more information from the treating neurologist and GI doctor to formulate my opinions.

Q Did you speak with Dr. Eyal Muscal? I'll give you the spelling for that later. Sorry.

A Similar answer. Given, you know, what we're talking about, I did not see a need to speak to any other treating providers or retained experts other than the four that we've been discussing.

Q Okay. And so the same would hold for Dr. -- Dr. Filipek, the neurologist?

A The same would hold true, yes, ma'am.

Q And those are physicians that -- strike that.

84

Those are, as you said, the treating providers, retained experts, those were physicians. Did you speak to any of Ethan's various therapists, non-physician therapists that he's had over time?

MR. PARKER: I'm sorry. I object to the first part of the question. The second part is fine.

Q (BY MS. PALEY) Okay. And I believe maybe one of those is actually not a physician but is a Ph.D. So I may have -- I may have messed that up. But let's strike that and I'll start again.

Did you speak to any of Ethan's various non-physician therapists that he's had over time?

A I did not, for a few specific reasons.

Q What are those reasons?

A Number one would be that, as a physical medicine and rehabilitation physician, I'm responsible for ordering therapy, from speech-language pathology, physical therapy, occupational therapy. Therapists cannot order it themselves.

With my extensive training, experience and skill set in my clinical practice, nearly daily I'm reviewing the plethora of all three of those main specialties on rehabilitative therapies. So I did not feel a need, given the information at hand, as

85

well as speaking with the specialists that are currently treating him.

And to clarify, another reason why I did not call the physicians that treated him in the past, because they were treating him in the past and it was my understanding that they weren't actively treating him. And those active physicians, I spoke to.

Another reason was scheduling and timeframe. I did not have time, I think, in the week to schedule that with treating therapists.

Q Wouldn't there be some value in understanding how Ethan had responded to, you know, speech therapy, physical therapy, OT with understanding the course of his progress in those therapies by speaking with the providers?

A So, again, given sort of my board certification and specialty, it wasn't as pertinent for me, given this totality of information at hand, right? Thousands of pages of medical records, approximately 50 pages is what the summary became, and speaking with the family and my direct observations and attempted examination with Ethan in his home. And so it may be helpful for a physician that's a general pediatrician or perhaps a non-medical provider, like others in this room. I

86

did not feel it would be necessary at that time to speak with them.

Q So it's not necessary to speak with them to understand the sort of course of his progress in developing your recommendations for future care?

A So I think basically it's the same answer I just gave, because I was able to review a significant amount of data, speak to current treating physicians, use my own education, skill set and experience to take a history from his mother, plus a site face-to-face visit with direct observation.

And similar to questions a while back on prescription of care or acute care management, these therapists are not trained for future medical care and recommendations like I am, as a physiatrist, as is outlined in my life care plan, as is outlined in the case management life care planning handbook.

And so I don't feel it is necessary, again, with my skill set, to have that discussion in the short, limited window to produce this thorough, comprehensive life care plan.

Q Now let's turn to your report, Page 63. Now, you list -- 63 to 64. You list 13 diagnostic conditions -- diagnostic conditions, right?

A 13, yes, ma'am.

87

Q Okay. And is the assumption that all of these were caused by heavy metal exposure? There's language as they pertain to Mr. Palmquist's relevant cause of injury.

A I'm just waiting to make sure we're all on the same page here. Page 63. In Section 4.1, yes, ma'am, that is correct. A quotation pertaining to Mr. Palmquist's relevant cause of injury followed by my 13 diagnoses.

Q Do you list these diagnostic conditions in what you believe to be like a descending order of importance?

A Not necessarily in that order, but more consistent with how I -- how I document things typically on my list of impressions or assessments, both in the hospital and/or in clinic, similar with other specialties like -- you know, trauma surgery is going to list their neurological complaints and injuries, their cardiovascular complaints and injuries. Similar with ICU doctors, kind of system by system.

And so I typically start with the neurological system because that's kind of my main wheelhouse. And so the first few -- meaning four -- are directly related to that. And then Condition

88

Number 5 is secondary to those neurological conditions as above. And then kind of just listing them on to get to Number 13.

Q So is autism not a neurological condition?

A So Diagnostic Condition Number 11, I have as autistic disorder.

Q Uh-huh.

A And so yes, it may be a neurological and other system or body part-affected disorder, but it's -- it's something that does not tell me and other physicians directly what the diagnosis is versus he has, let's say, Number 3. He has objective evidence of complex partial seizures and bilateral frontal temporal epileptogenic process.

And so I don't typically like to list syndromes and constellation of symptoms. I like to go into specific things, which are basically, you know, the first 1 through 10, if you will, diagnoses.

Q Okay. And so you're listing autism after 1 through 10 because it's a syndrome or constellation?

A That would be a very global, general summary. I would -- I would agree with that.

Q I'm looking for a chance to cut out a few questions.

89

MR. PARKER: Sure. Of course.
MS. PALEY: Hence, the silence.
Q (BY MS. PALEY) Just curious. I think I forgot to ask about this specifically earlier. Did you review and rely upon Ethan's perforin testing as part of your analysis in this report?
A So I did list that as a document I reviewed. However, that doesn't necessarily lead to my central opinions on Page 63 and all the future medical care afterwards, because I'm -- I'm seeing, diagnosing, observing, his function, diagnostic conditions during this mid-March timeframe. So I'm not relying upon that specific test that you're describing.
Q Okay. And just so I've got clarity, you said, Doesn't necessarily lead to my opinions. But I think by the end, you said you're not relying on the perforin testing. I'll ask clearly so we can just get that clear.
Are you relying on Ethan's perforin testing to develop your opinions or your recommendations of care in this case?
A So, again, I'm not relying on just that one thing, but we have to take the entire body of data with this large amount of medical records and

90

laboratory studies to then lead us to the point that we start on Page 63. Currently, as of the publication March 30th, these are the specific diagnoses and impairments.
Q And so what's your background in perforin analysis?
A I do not have a background in perforin analysis.
Q Did you use the pattern recognition guides and the perforin testing results to determine what metals you think Ethan was exposed to?
A So I don't think I can answer that question fully because I reviewed the document of the testing and moved on. So I did not rely upon it or specifically use what you're describing as guides, as we discussed earlier, to do an independent analysis of his laboratory studies.
Q So you did not rely upon it or specifically use the perforin testing results as, you know, interpreted by the guides as part of your assessment here?
A This is just one or three pieces of paper out of thousands with a laboratory study result. And so I'm not sure if you're asking me rely upon it exclusively. But, again, it's the observations and

91

diagnosis of the current impairments that Mr. Ethan Palmquist has, which I'm outlining, is the basis for all my future medical care moving forward.
Q Did it have any role in your opinion? That's all I'm wondering. I know you -- I know you looked at it. I know you looked at a lot of things. And I'm just wondering if it had any weight in your opinions.
A I guess I would describe it as the weight is consistent with the treating medical providers' documents where they are utilizing it to help form the diagnosis. And so, to me, it is consistent with their medical records. I'm not sure how I can -- how I can further answer the question though. I think we've covered it.
Q And do you have any sense of other conditions or exposures that could increase perforin levels?
A At this time, I don't have an opinion on that.
Q Okay. So let's -- just a second. I may be able to short-circuit some questions here, just to -- if I get clarification.
You're not offering an opinion that any specific baby food consumption caused Ethan's 13

92

diagnostic conditions; is that right?
MR. PARKER: Objection as to form. It has been asked and answered.
A I'm sorry, can you just repeat the question, please.
Q (BY MS. PALEY) Sure. Are you -- I know that you are offering an opinion as to metals generally. But are you offering an opinion as to whether baby food consumption specifically caused any of Ethan's 13 diagnostic conditions?
A So I have not been asked to do that --
Q Okay.
A -- or retained to do that. And I would utilize treating medical providers' opinions, as well as other retained experts with a different experience than I have, to answer that question. I don't have an opinion on that right now.
Q Okay. So, for example, when you've got Condition 7 here, Crohn's disease, you know, we see it in Ethan's records, you haven't studied whether any, you know, children who are fed commercially made -- US commercially made infant foods have elevated rates of Crohn's disease as compared to like children who eat homemade foods or baby foods made from outside the US?

93

A What was your specific question in that, please?
Q Yeah. Let's talk about Crohn's disease.
A Got it.
Q Okay. Have you done any analysis as to whether children who eat commercially made US baby food have elevated rates of Crohn's disease as compared to other populations that don't eat that food?
A That is something that I have not been asked to do. And so no, I would not have completed that type of analysis. That is outside the scope of what I've been asked to do for completion and publication of this report.
Q Okay. Let's talk about Diagnostic Condition 10, autoimmune encephalitis.
A Uh-huh.
Q Now, this is -- so the laypeople, me, get it. This is inflammation of the brain resulting from some form of autoimmune reaction; is that correct?
A That's a pretty good, general, correct summary.
Q Okay. And so, Doctor, I see in the records, and your report specifically, a suspicion of autoimmune encephalitis.

94

A Uh-huh.
Q Do you know whether it was ever firmly diagnosed?
A I would just have to review some of those records. But I do recall there was a specific antibody that was positive. And that's why I have that in the diagnostic condition. And treating physicians had given him that diagnosis as well, contributing to his abnormal function in his brain.
Q So let's look at Page 43 of your report.
A Sure.
Q And it's a September 26, 2021, entry. And I'll read out loud the second sentence in that entry. It's pretty long. So bear with me. Dr. Krigsman reported Ethan underwent a lumbar puncture by neurology to obtain CSF --
That's cerebral spinal fluid?
A That's correct.
Q -- for testing for cerebral folate deficiency, antibodies and any evidence of autoimmune encephalitis. Unfortunately, the laboratory did not request the autoimmune encephalitis panel and, thus, did not have that data. And the remainder of the CSF was unremarkable.
Based on this September 26th, 2021,

95

record, do you have any -- or any other records that you've reviewed, do you have evidence that autoimmune encephalitis was actually diagnosed?
A So my -- if my memory serves me well, I was looking at the following note on Page 43 as well as Page 44, that there was some positive antibody levels. And then he also had what's called IVIG -- intravenous immunoglobin -- in that treatment and then did have some improvements.
And so without having all of those specific records in front of me again, I do recall that the treating physicians diagnosed him with that and he underwent treatment for that.
Q Well, no doubt he had IVIG. But let's look at this next sentence after what I read. It says, Dr. Krigsman noted that IVIG had been started on the presumption of autoimmune encephalitis. Ethan received two doses so far, and no significant effects have been noted to date.
Do you have any later records that turn that presumption into a firm diagnosis?
A I think it's Dr. Muscal's record -- M-u-s-c-a-l -- on October 4, 2021.
Q I'm looking at it.
A Third and fourth line, starting on the

96

third line. Dr. Muscal states, Ethan appeared to have some improvements since starting IVIG and appear to have had better mood since the second infusion.
So that would be slightly different summary compared to what you quoted on Page 43 from Dr. Krigsman.
Q So that goes to the no significant effects. Do you have any medical records that show that the presumption of autoimmune encephalitis actually turned into a diagnosis?
A I would definitely have to review them again to answer that question, instead of flipping through my medical record summary here --
Q Okay.
A -- and taking up too much time right now.
Q Okay. But just like right here, right now, nothing is -- nothing is coming to mind?
A Well, those -- those things that -- that I mentioned are coming to mind, as well as the antibody earlier I mentioned, which is GAD. And that would be on Page 41 from Dr. Proud, June 15th, 2021.
Q And this is -- this is before the lab failed to do the -- the panel, right? So this is earlier. Autoimmune encephalitis still hadn't been diagnosed?

97

A That's not my understanding from reviewing the June 15th record from Dr. Proud.
Q So you believe, based on the June 15th record, that autoimmune encephalitis had actually been diagnosed even in the absence of the -- the panel?
A So I'm not exactly sure what you're trying to ask me here. And what I'm able to specifically state is on Page 41. The neurologist is saying on June 15th that Mr. Ethan Palmquist had the lumbar puncture to do a cerebral spinal fluid analysis. There, what -- what I'm seeing later on is that there is evidence of inflammation with elevation of the CSF opening pressure. And Dr. Proud states, Autoimmune encephalitis panel serum showed only GAD positive with mild elevation.
So I think that is the main data points on the working diagnosis of autoimmune encephalitis.
Q But then we see on September 26th that actually, whoops, he underwent the lumbar puncture but the lab did not do -- unfortunately, the laboratory did not request the autoimmune encephalitis panel, correct?
A Well, I think having still a positive GAD can lead to a physician making the determination of

98

that differential diagnosis perhaps even without that confirmatory panel.
Q You actually didn't speak to Dr. Proud, right?
A As we discussed earlier, I did not speak to Dr. Proud.
Q And it's Dr. Krigsman here who's noting it's a presumption of autoimmune encephalitis but the panel hadn't been done, right?
A I think you're quoting the September 26 note from Dr. Krigsman?
Q I am, yes.
A I would agree that's what he states, and that's why we try to be objective and exactly document what is in the medical documentation records from treating physicians.
Q Okay. Let's -- let's talk about your clinical practice a little bit.
A Sure.
MR. PARKER: Is this a good time for a break if you're --
MS. PALEY: Yeah. We -- yeah.
MR. PARKER: Quick break.
MS. PALEY: It's a change of subject. That's fine.

99

THE VIDEOGRAPHER: Okay. The time is 10:26. We're off the record.
(Recess from 10:26 a.m. to 10:43 a.m.)
THE VIDEOGRAPHER: The time is 10:43. We're back another record.
Q (BY MS. PALEY) Welcome back, Dr. Hyzy. Hyzy, sorry. Sorry.
A Hyzy.
Q Hyzy. I was saying it in my head and it came out wrong.
A No problem.
Q Let's talk a little bit about your kind of day-to-day practice. What percentage of your time do you spend in clinical practice?
A So the significant, overwhelming majority is clinical practice, meaning both hospital and outpatient clinic. Last year, it was probably 95 percent with only 5 percent of my legal work. This year, over the last three or four months, my legal work is probably closer to 12 to 14 percent. Over the last quarter, it's a little bit more.
Q Okay. And when you say med/legal work, is that preparing life care plans?
A That would be one part of it.
Q Okay. What other kind of med/legal work

100

do you do?
A Independent medical examinations. IME.
Q IME. All right. In your clinical practice, what conditions or injuries do you most commonly treat?
A Things affecting the neurological system, acquired brain injuries, traumatic brain injuries, strokes, brain tumors, seizures, spinal cord injuries -- sorry, I realized I was going fast. Spinal pain, spinal degeneration, radiculopathy, things regarding the musculoskeletal system. So that would be different areas of joints, arthritis, tendonitis. Patients with functional decline from aging, from diagnoses. I treat patients that have amputations. I treat patients with weird types of neuropathy, neurological disease, things like complex regional pain syndrome, peripheral polyneuropathy.
So that is the general depth and breadth of what most physical medicine and rehabilitation folks see and treat. And then I also have just additional skill sets for procedural interventions, a little bit more complex hospital-based trauma management, and then this type of work as well, offering my expert opinion.
Q Okay. And what percentage of your

101

patients -- just sort of estimating -- would you say are pediatric patients?
A Probably less than 5 percent on average over the last five years.
Q And what are the sort of most common injuries you see among the pediatric patients?
A It depends on which setting. So if it's -- if it's in the hospital setting, oftentimes they buzz me typically from more, We don't know what the diagnosis is. Can you come in and review with us and weigh in on diagnoses? And then rehabilitation and medical care or hospital is more kind of trauma or acquired brain injuries. So that would be like partial drowning, lack of oxygen, things like that. It can be infections.
In the clinic, though, it's more what we've kind of been talking about, procedural interventions, in my outpatient clinic.
Q And what percentages of your patients would you say have global neurodevelopmental delays?
A That's going to be a very small percent.
Q And you're a member -- are you a member, I should ask, of the American Academy of Physician Life Care Planners?
A I am a member.

102

Q Okay. And are you aware that they've put out a book on the tenets, methods and practices of life care planning?
A Yes. That's part of my study to then, you know, have the capacity to author life care plans, along with reading the Life Care Planning and Case Management Handbook, third edition, May '17 publication, I think. On top of obviously the extensive skill set I have in my internship, in medical school, in residency, in fellowship and in clinical practice.
Q And I've -- the American Academy will be happy. I paid my dues to them by buying a copy of their book. And then they'll also be happy that my duplicating department refused to scan the whole thing because of copyright issues. But they would scan some chapters for me to use today.
MR. PARKER: Okay.
Q (BY MS. PALEY) So I'm going to just share --
A Sure.
Q -- a few -- we're going to look at a few pages here.
A Thank you.
Q So everyone is being very respectful of

103

copyright, and it's a purchased version of the book.
A Exhibit 8.
Q Exhibit 8.
(Exhibit Number 8 was marked.)
A Understood.
Q (BY MS. PALEY) Excuse me. Correct.
Okay. Does this book look -- I mean, it's not the full book, but does this look familiar to you?
A Yes. This looks like the first edition, the exact same book that I have, as well as part of what we discuss at the academy meeting.
Q Okay. And I will just show you here, I brought the full book in case we need to look at it.
And if you look at page -- the third page in -- it doesn't have a page number, it says Copyright 2017.
A Yes. I see that.
Q Okay. So is the version of the book that you would use as part of your life care planning practice?
A Yes, ma'am.
Q Okay. And let's look at the authors and contributors. And they're on, what does have a page number, Page 2.

104

A Yes.
Q Okay. So is it true that many of these folks --
THE VIDEOGRAPHER: One minute, please. Did your mic come off or something?
MS. PALEY: Oh. It's on. I bumped it as I moved over to the book.
THE VIDEOGRAPHER: I just noticed you got real quiet real quick.
MS. PALEY: Test, test.
THE VIDEOGRAPHER: We're good now.
Q (BY MS. PALEY) Okay. All right. Let's look at the authors and contributors on Page 2 of the Physicians Guide to Life Care Planning. Would it be fair to say that many of these folks are also involved in Physician Life Care Planners, LLC?
A I don't mean to correct you. I just want to a hundred percent understand. Physician Life Care Planning, LLC is the company. And that's the company I'm working with that helped me do this plan, correct?
Q Correct.
A All right.
Q That's what I meant. Sorry. Physician Life Care Planning. I can re-ask the question if

105

that would be helpful.
A Sure.
Q So is it fair to say that many of the folks who are involved in this book as authors and contributors are also involved in Physician Life Care Planning LLC or Physician Life Care Planning, whatever the organization's tax status is.
A So, you know, based upon you presenting me this page with name recognition of a handful of these physicians, and understanding the baseline context that the company is physicians that do life care plans -- that's the name of the company; so you have to be a physician. This is the Exhibit 8, a, Physician's Guide to Life Care Planning, then yes, I recognize some of these physicians because this is the tight-knit group of physical medicine and rehab doctors that are physicians that do offer life care plans. So it's all consistent.
Q Okay. And in this tight-knit group -- I know Todd Cowen works with PLCP, I think I've got -- is that correct?
A I mean, that's my understanding.
Q William Davenport?
MR. PARKER: For our court reporter -- just a second. I think she meant Todd Cowen,

106

C-o-w-e-n.
MS. PALEY: Yes, C-o-w-e-n. Sorry.
MR. PARKER: I'm enjoying this realtime.
MS. PALEY: It's great, isn't it?
Q (BY MS. PALEY) Mr. William Davenport.
A Yes.
Q In fact, he prepared the present value analysis for this report, right?
A Yes. I know Mr. Davenport.
Q And he's involved in Physician Life Care Planning?
A He's involved in the company, Physician Life Care Planning, correct.
Q Okay. Can -- we -- maybe we'll just save a little time. Can you walk me through and tell me, of the folks listed here, who you know has some involvement in Physician Life Care Planning.
A When you say "involvement," do you mean an expert like myself that takes cases? Or do you mean administrative involvement?
Q Either or both.
A Okay. So I've met Dr. Cowen at conferences, and he's an expert, like myself, is my understanding, to do life care plans. Dr. Davenport is part of the company -- I'm sorry, Mr. William

107

Davenport is part of the company, Physician Life Care Planning. He's not a physician. His qualifications are outlined there for you. Dr. Joe Gonzales, MD, is an expert that authors life care plans and part of the company, Physician Life Care Planning. And then I recognize a few other names. I've met Christopher Leber in person at conferences. Sasha Iversen and Jason Marchetti I've met via like a telemedicine type of Zoom conference as well.
MR. PARKER: I object as to responsiveness. To the extent -- she's not asking you if you met them. She's asking you if they're affiliated with PLCP.
Q (BY MS. PALEY) This is a first. But yes, that's my question.
A As far as I know, everything I already mentioned, those physicians -- Iversen, I-v-e-r-s-o-n, Dr. Iversen, yes, she does life care plans. Dr. Marchetti, M-a-r-c-h-e-t-t-i, yes, he does life care plans. And so the really only knowledge I have of those physicians are that they are physical medicine and rehab doctors and they offer life care plans. And I think and assume, but don't want to speculate, that they do that exclusively with Physician Life Care Planning.

108

Q Okay.
A I guess you'd have to ask them that question.
Q What about Dr. Angel Roman?
A I've heard that name. I don't think I've ever spoken to him. I do think he's affiliated with Physician Life Care Planning, given these credentials. And, you know, I understand I think he's practicing in Texas.
Q And are there any other individuals listed on this page that you know have some affiliation with Physician Life Care Planning?
A The other names on this page I don't recognize.
Q Okay. And so I think you answered this before, but I'll just -- because I don't remember it. You've read this book?
A Yes, ma'am.
Q Okay. Were you ever tested on this book as part of engaging with Physician Life Care Planning?
A No, ma'am.
Q Okay. Is this essentially a guidebook that's used as part of Physician Life Care Planning work?

109

A I think that's understood in the title, right. A Physician's Guide to Life Care Planning. So this is something that can help, a guide, for physicians authoring life care plans.

Q And where appropriate, has your report used sort of language that's come from here to explain different parts of your life care plan?

A So not necessarily specific language, but in my life care plan, on some of the initial pages we do have some headings that have references back to this specific book, along with the case management life care planning handbook. And so those are the two main things that I have read and used then to have a transparent methodology to then kind of go through this framework to then create my life care plan.

Q Okay. And I mean, do you -- do you generally -- strike that.

Is there anything that when you were reading this book you said, Huh, I don't really agree with that, or, I think I have a difference of opinion?

MR. PARKER: Object to the form only as to "book" as opposed to Exhibit 8.

MS. PALEY: Well, we can -- we can enter

110

the book itself as an exhibit if you wish. It's --

MR. PARKER: I'm not requiring that. I would just -- for clarity, you were talking about Exhibit 8, which I think was a chapter of the book.

MS. PALEY: Yeah, several chapters, yes.

MR. PARKER: But if you want to ask the question as to the book -- you don't need to make it a exhibit, but just be sure to tell me the book. That's all I'm saying.

MS. PALEY: I see. I said as opposed to Exhibit 8. Thank you for the clarification. I actually appreciate that, Charles.

MR. PARKER: I mean, for the first time I'm going to let somebody answer a question about a whole book.

A What was your question, Ms. Paley?

Q (BY MS. PALEY) Is there anything when you were reading this book -- which I'm holding up, Physician Life Care Planning book -- where you said, I really don't agree with that statement in the book, or, I have a difference of opinion with what's being stated here?

A I don't think I've ever came to that conclusion or specifically -- your question was -- stated that or said that.

111

Q Did you think that at any point?

A You're asking me did I ever think that --

MR. PARKER: I will object to form as to that, because we can't go into what he thought in the past. I apologize.

Q (BY MS. PALEY) Do you recall having any differences of opinion with what was stated in the book versus your sort of philosophical or methodological approach to life care planning?

A I think the answer is no.

Q How many life care plans have you prepared?

A As of today, how many are fully published, completed?

Q Sure.

A Approximately 100.

Q And about how many do you have in the works at varying stages of completion?

A That's a tougher one to answer, but the caveat is that some have been retained with deadlines into the fall and winter. So there is no work on them yet, right. But they're sitting there with a deadline in the future. Another 25 perhaps.

Q Have all of these life care plans been for Physician Life Care Planning?

112

A That's correct.

Q Okay. And how did you become involved with Physician Life Care Planning?

A That's a great question. I am glad you answered [sic], and I apologize for the length perhaps of this.

So because trained in Texas, my residency -- we touched on University of Texas. And even before that, I had an internship that allowed me to do a lot of different things: Organ transplantations, surgeries in the middle of the night, pediatric ER, pediatric surgery, all these different subspecialities during my internship, plus those same subspecialities are in medical school.

Once I became confident in my interventional practice after my fellowship, I was speaking to some of my mentors in Texas that trained me. And they were saying, Well, you're getting back into the hospital. We know your skill set. We know that you would be a good person to take in complex cases and review them. Have you ever heard of life care planning?

And so at some point in late 2019 or early 2020, I was having these discussions with my mentors because I was already giving some of my private

113

practice patients away to our junior doctors or the fellows that were training that year, and I had a little bit more time to develop some of my skills that were on pause, my hospital skills.

So then I had discussions with the Physician Life Care Planning team in San Antonio, Texas. And then went through some training and, you know, became an expert for them and started taking on cases in 2020.

Q So before 2019 or 2020, had you done any work in the life care planning space?

A Not me physically doing the work, but there is publications in our journal, American Academy of Physical Medicine and Rehabilitation Journal. And so there was a little bit of knowledge I had about this. And then if we break down little aspects of the life care plan, you know, I was doing clinical practice of medicine that encompassed all this stuff. Just like yesterday, I had to do a peer to peer with an insurance company director, getting a patient from the hospital to acute rehab. You know, that's kind of part of this projecting future medical costs.

So to answer your question, I have not ever authored a life care plan prior to starting with Physician Life Care Planning.

114

Q Okay. And what training was required to become a physician life care planner with Physician Life Care Planning?

A Number one, you have to be a board certified physical medicine and rehabilitation specialist. So you have to complete the residency, the four-year residency, and pass your boards. And then you have to have an active clinical practice. So that's baseline.

Specific training then was an initial American Academy of Physician Life Care Planners conference was recommended. Read the whole book, buy the book that we're discussing, A Physician's Guide to Life Care Planning. Then I reviewed, based upon the recommendations, the other large main book, which I have quoted on Page 3 here. And that's the Life Care Planning Case Management Handbook. Then some self-study regarding different things, reviewing different types of redacted life care plans as examples. And then starting my first case all -- I think my first five cases all were discussed with Dr. Gonzales, Dr. Joe Gonzales.

And so that was all in this first year of 2020 to get me up to speed on the framework, methodology, cost analysis, transparency, et cetera.

115

Q And part of how you've been able to do, you know, a hundred or so of these in the last couple of years is that you kind of have a template or a framework that you use that comes from the Physician Life Care Planning group, like -- I think they may even have like legal protection over their framework.

Do you utilize that framework in your planning?

A Yeah. The Physician's Guide to Life Care Planning book that we're mentioning kind of goes through the framework as well as that initial, much thicker, thousand-page textbook, case management life care planning handbook. So the framework is based upon that.

And then with Physician Life Care Planning, we do have the framework that we kind of outline here at the very beginning, you know, with content, Section 1 through 8, et cetera. And so that gives me a framework, just like how I have my subjective, objective, assessment, plan framework or different things that I would do on a new consultation in a hospital. So that is the framework for my life care plan for Mr. Palmquist.

Q Believe it or not, I actually bought that other book too. I didn't bring it today.

116

But do you see any tensions between the life care planning process that's laid out in A Physician's Life Care Guide to Life Care Planning and the other textbook that you referenced a moment ago?

A I'm sorry, what was the first part of your question?

Q Do you see any tensions between the life care planning process that's laid out in The Physician Guide to Life Care Planning and the other textbook that you referenced having reviewed?

MR. PARKER: I would object to form. But I find it such an interesting question, I want to see what your answer is.

A Okay. Great.

So interestingly enough, I did review this textbook, the specific third edition, May '17, acquired brain injury chapter, which is mostly trauma, technically acquired, and any other insults acquired, for this specific Ethan Palmquist case. That's a statement. Back to answering your question.

I'm not exactly sure what you mean by "tensions," because the large textbook I believe was authored mostly by two Ph.D.s and then lots of other reviewers and contributors. And A Physician's Guide

117

to Life Care Planning, smaller guidebook, as we're discussing, you've provided -- or Exhibit 8 as a partial copy of this, was mostly authored by physicians, medical physicians, not Ph.D.s.

So that's -- that's my foundation, but I still don't exactly understand how you want me to answer "tensions." I don't understand that question.

Q (BY MS. PALEY) I might come back to it, but I'm probably going to move on now.

MR. PARKER: Okay.

Q (BY MS. PALEY) Are there any medical school classes in life care planning?

A I don't recall having any.

Q Is there a medical residency in life care planning?

A Residencies would be determined by the American Board of Medical Specialties. And there is no residency in life care planning because that is not an isolated American Board of Medical Specialties-designated physician specialty like anesthesia, physical medicine and rehab, neurology, neurosurgery.

Q Okay. So I might know the answer to the next one, then, but I'll ask, just to get your understanding. Is there any medical fellowship in

118

life care planning available to MDs?

A So there are certifications or courses. But I define a medical fellowship as a postgraduate medical year after you finish a residency. So I did a fellowship in a interventional spine and pain management.

THE REPORTER: In a?

THE DEPONENT: Interventional spine and pain management.

A Or a neurologist can do a fellowship in pediatric neurology, or the neurologist can do a fellowship in epileptology, et cetera.

And so I just want to answer your question but really understand what we're talking about. Because fellowships are additional years of training where doctors -- whether you're seasoned and you go back to training or you come straight out of residency -- are still supervised by attending physicians in a training program. That's what a fellowship means to me as a board certified, fellowship-trained physician.

But there's no medical fellowships, in my opinion, that are outside of that realm I defined. But yes, there are classes or courses a physician or non-physician can take to learn about life care

119

planning.

MR. PARKER: Okay. Doctor, you're -- the photographer, his video is getting a great shot of your knee.

THE DEPONENT: Sorry.

MR. PARKER: And if a shorter answer can do, it's okay.

THE DEPONENT: Gotcha.

MS. PALEY: I ask you not to coach the witness, Charlie.

MR. PARKER: Oh, I was trying to help you. I apologize. I wasn't trying to coach him.

MS. PALEY: Okay. Thank you.

MR. PARKER: That was an innocuous question.

Q (BY MS. PALEY) So is the short -- is the short answer, There are classes but there's not a fellowship?

A I would agree with your short answer.

Q Has -- have you had any involvement in life care planning outside the -- like litigation context, essentially?

A I offer future medical recommendations similar to a life care plan outside of litigation. However, I've never been retained for or asked to

120

provide a life care plan outside of Physician Life Care Planning, LLC.

Q And have you received any sort of litigation training or deposition training from Physician Life Care Planning or the American Academy of Physician Life Care Planners?

A So there's discussions with physicians, things like that, discussions with attorneys with how to be cordial, professional, objective things like that. To answer your question, yes.

Q And you are being very cordial and professional. So thank you.

And are you aware of anyone outside of Physician Life Care Planning, PLCP, who cites the American Academy of Physician Life Care Planners guidelines, the tenets, methods and best practices for Physician Life Care Planners -- sorry, that sentence got very long. I want to restart it.

Are you aware of anyone outside the PLCP who cites the guidelines in this book that we're talking about here, A Physician's Guide to Life Care Planning --

A Uh-huh.

Q -- anyone else from outside PLCP who has cited these as part of like a peer-reviewed published

121

literature?
A So I'm aware of other physicians that are not part of Physician Life Care Planning, LLC, in San Antonio, Texas, the group I'm involved in, that have participated in conferences and they have referenced this book. I've been involved in these conferences, speaking to these physicians.
Q Are you aware of any peer-reviewed published literature that has referenced the book that we're discussing?
A I think it is referenced in some of the PM&R journals, so the American Academy of Physical Medicine and Rehab. I don't have that information in front of me. So I think it is, but I'd have to verify and get back to you on that.
Q Okay. Let's look at your expert appearances, Exhibit 3. I think we can probably work through this one pretty quickly.
A Sure.
Q Now, I see nine depositions and one court appearance. And I hear you had a deposition yesterday. So you're at ten depositions and one court appearance; is that correct?
A One, two, three, four, five, six, seven, eight, nine, ten. Correct.

122

Q Maybe you can just -- we can walk through these quickly and you can tell me what the injuries were in these cases, if you recall.
A Okay.
Q So let's look at the first one. And I'll just refer to it by the last name.
A Okay.
Q Reynolds.
A Trauma, head fracture.
Q Fahrenbruch.
A Acquired hypoxic brain injury.
Q Wells.
A Motor vehicle collision, lumbar spine radiculopathy.
Q Shahbazian.
A Trauma, laceration, complex regional pain syndrome.
Q Shrode.
A Acquired hypoxic brain injury.
Q Murray.
A A peripheral nerve injury called atypical facial pain.
Q Schones.
A Cervical spinal cord injury.
Q Santella.

123

A Traumatic brain injury.
Q And was that like an acute injury? Sorry, I'm not a doctor.
A Mr. Santella? Is that what you mean?
Q Yeah.
A His was traumatic from a medical procedure complication.
Q Okay. Thank you.
Beard.
A Cervical lumbar injuries, motor vehicle collision.
Q And the one that you did yesterday.
A The one I did yesterday, I'm the treating physician for injuries and impairments after a motor vehicle collision.
Q Okay. So for the deposition you did yesterday, you did not prepare a life care plan as part of that -- your work in that case; is that correct?
A That's correct. And not all the other nine have been life care plans either.
Q Okay. And which of them have been life care plans? If we can run through them.
A It might be easier to say which one wasn't, if that's okay.

124

Q Okay. Sure.
A Mr. Beard was an independent medical exam.
Q Okay. And then the one yesterday. Okay.
And so the other eight were life care planning work, correct?
A Correct.
Q And then you have one court appearance. Perng? It's very small?
A Yeah. P-e-r-n-g.
Q Okay.
A So --
Q Was that in the life care planning space?
A Correct.
Q Okay. And what was the injury there?
A Multiple traumatic injuries from a motor vehicle collision.
Q Okay. Were -- I think it's safe to say none of these related to metal exposure; is that correct?
A Some patients had surgery and they have metal inside their body now.
Q Did your opinions in any of these cases relate to injuries that you believe to be caused by metal toxicity?
A No, ma'am.

125

Q And were any of these for children?
A The pediatric IMEs and life care plans I have authored, I have not been deposed on or trial on. All that stuff is scheduled, up and coming.
Q Okay. So for the up -- for the up and coming -- sorry. Strike that.
For the other life care plans that you've done that either -- strike that again.
You said you've done about a hundred life care plans, right?
A I've completed approximately a hundred, yes, ma'am.
Q Okay. For those that were not covered by the list of testimony you've already given, about how many of those are for children?
A I'm going to define "child" as under the age of 18. And so I think I have anywhere between six to seven life care plans and IME for children under the age of 18.
Q And what if you take out the IME? What about just life care plans?
A That would be one major one. So that would be five to six.
Q Okay. And of the other life care plans that you've done that are not listed on the testimony

126

list, were any of those cases in which the injury is autism?
A No, ma'am.
Q Okay. Crohn's disease?
A No, ma'am.
Q Global neuro developmental delay?
A The other children do have that diagnosis as well, depending on which one it was and their specific injury.
Q Were any of those other plans -- whether for children or adults -- related to allegations of toxic levels of metal exposure?
A No, ma'am.
Q Okay. In your life care planning -- or now I should ask, for the life care plans that you have in the hopper, you know, scheduled out through the fall, to the extent that you know about the injuries, do -- would any of these life care plans likely address autism, Crohn's or metal exposure?
A There are some pediatric cases in the hopper, as you term it. So that, you know, means cases that I've been retained on but have not started on. No to Crohn's and heavy metal. Some of the children I think will have some autism or global neurodevelopmental delay diagnoses. I just have not

127

gone through all the records yet and produced my plan. So I can't a hundred percent answer that.
Q Fair enough.
And in your life care planning, have you used the same essentially template that you used for Ethan's report?
A I prefer to call it more of a framework, because it's not template that I fill in, right? It's very unique per person, with the examination and my diagnoses and the medical record.
The framework is similar because that is the best practice, transparent, reproducible via the two documents we discussed: The textbook and then the guide.
Q Okay. And within the framework -- I'll use your language, framework -- are the sort of major judgment calls that you make based on your analysis of medical records and other materials, are they essentially types of care potentially needed, frequency and duration of care and cost of care?
A In general, that's one part of my framework.
Q Okay. What are the other parts? I know you have -- you do a summary of the medical records, but --

128

A Yes, ma'am. Basically under contents, those sections. So overview of what it is: Medical records summary, my examination. Then opinions, which are diagnoses, impairments, disabilities and duration of care, life expectancy.
Then what you just described, future medical requirements, cost vendor analysis and then total cost. And then last section would be exhibits for Mr. Palmquist. They were the pictures that I was able to take at his house after consent from his parents.
Q And would you say -- strike that.
At this point what -- roughly what percentage of your income would you say comes from life care planning?
A So it's variable on the amount of clinical work, but it would be somewhere, you know, in that ballpark of 12 to 15 percent, depending on how many procedures I do versus how much hospital call or consults I do versus if I do eight life care plans a month or five or ten.
Q Okay. And I know you're a physiatrist. We've talked about the sort of work you do. Just to sort of round this out, you agree that you're not a toxicologist?

129

A Yes, ma'am.
Q Okay. And you've probably been through this before. But not an expert in, you know, metals and metals toxicity?
A Yes, ma'am.
Q Not a child neurologist?
A I do have significant experience and training, both in medical school and residency on doing rotations in pediatric neurology. But you're correct, I'm not a pediatric neurologist because I am a physiatrist.
Q Okay. And the same for -- you can take out the "pediatric." Just not a neurologist; you're a physiatrist?
A At times I have to do all the work the neurologists do, for whatever reason. But that's correct. That was not my residency training.
Q And in terms of psychiatry, either pediatric or child -- whichever the correct term is -- not a psychiatrist for either kids or adults?
A Also have lots of training in psychiatry through medical school and residency. I am not a psychiatrist, as you point out. That's correct.
Q Okay. Not a gastroenterologist?
A Thank goodness, no.

130

Q Okay. Not a pediatrician?
A No. Again, lots of pediatric training in focused pediatric physical medicine and rehabilitation, which includes a lot of general pediatrics.
Q Not a child development expert?
A Outside my own two children, the answer is no.
Q Okay. Not an epidemiologist?
A Agreed.
Q Okay. Not an epileptologist? Which is quite a mouthful.
A Agreed.
Q Okay. You know what, I'll split that up because I essentially had two questions there. I'll take out the "quite a mouthful."
Not an epileptologist?
A I'm not an epileptologist.
Q And not an expert in perforins?
A That's correct.
Q Let's talk a little bit more about the process of putting together your life care plan. You understand that the Palmquists have private health insurance, right?
A You can make the assumption. I did not

131

review those details. I don't think I've ever seen their health insurance card ever.
Q Actually, their health insurance card is listed on your list of materials.
A I forgot that.
Q Which is what made me think that maybe you knew that they were insured. I can try to find the page, but -- let's see.
MR. PARKER: I agree they have some insurance.
Q (BY MS. PALEY) Page 53.
MR. PARKER: Perfect.
Q (BY MS. PALEY) Okay. Page 53, Blue Cross Blue Shield of Texas insurance card for Ethan Palmquist. So --
A Yeah. That was probably two seconds of looking at that picture.
Q Okay. But you -- and we -- I'll just ask the questions.
MS. PALEY: You know, I know that, Charlie, you may not like them, but it's fine. I think we can get through them quickly.
Q (BY MS. PALEY) Have you reviewed terms of their health insurance?
A No, ma'am.

132

Q Have you determined what services or providers are covered and at what costs?
A No.
Q Okay. So is it accurate to say your life care plan doesn't reflect the Palmquists' likely cost for care under their insurance coverage?
MR. PARKER: No objection.
A I disagree. I think that's incorrect.
Q (BY MS. PALEY) Dr. Hyzy, if you don't know the terms of their insurance coverage, how can you testify that your life care plan reflects the likely costs of Ethan's care under their insurance coverage?
A That's a great question. I think I will answer that in a second. I got the pages flipped around here.
The reason why I say it does reflect their possible coverage options is because of how we do -- how I did their cost vendor analysis based upon where they live.
THE REPORTER: Cost of -- what was it?
THE DEPONENT: Cost vendor analysis. Yeah, I'm sorry.
A It's in here in one of the sections.
And so in my experience in my private

133

practice and in hospital, patients have coverage in a geographical area based upon providers, the type of insurance, et cetera.

And so pricing out things like -- I'm on Page 86 -- medications is directly related to the surrounding pharmacies in Pearland. Page 83, the physician specialists are, again, directly related to those providers, physicians in their geo ZIP code around Pearland. So that's how I would answer that.

The cost analysis is based upon their location, which typically includes providers in network on their, as you mentioned, Blue Cross insurance card.

Q (BY MS. PALEY) When -- but you report the UCR80s, correct, for some types of care?

A I guess I would clarify, not necessarily for some types of care but to price out the specific care that is available via the database.

Q And Doctor, you understand, as someone with an active clinical practice, that the UCR80 does not reflect necessarily, or even very often, what an insured individual will pay out of pocket under any given insurance plan, correct?

A The UCR 80th percentile, as I describe on 77, 78, would be those charges that we priced out

134

given the geographical location for 80th percent of all charges submitted in that area. So those are submitted charges.

There's nowhere that I recall or I'm seeing that I am stating UCR80 is a patient-specific co-pay or deductible.

Q And that's not really all I'm getting at. The UCR80s are not meant to reflect what you believe the Palmquists would pay out of pocket necessarily under their -- sorry, under their current insurance.

A These are two separate things, Ms. Paley.

Q Okay. When you provide the UCR80s in your life care plan, are you stating to a reasonable degree of medical certainty that you believe that those UCR80 charges from providers would accurately reflect the out of pocket for an insured individual under the Palmquists' insurance?

MR. PARKER: Object as to form.

A So I'm not exactly sure how to answer that, because this is the usual, customary, reasonable 80th percentile of submitted billable charges. This is not what you're describing as, what I mentioned earlier, co-pays or deductibles with health insurance. And that is not the methodology for -- for life care planners, whether they're

135

physicians or non-physicians, because I can't speculate the same health insurance network benefits and other versions of those -- those things that may or may not be available and accessible to the family or any patient at any time.

Q (BY MS. PALEY) Exactly.

So submitted billable charges are not the same as what a patient might pay out of pocket. That's the simple proposition I was just trying to get at.

A Well, no, that's different.

MR. PARKER: Objection as to form.

Go ahead.

A That's not my understanding, Ms. Paley, of your question. Because I thought the first question you said, What would they pay with their insurance? And then I thought you just said now, What do they pay out of pocket.

Q (BY MS. PALEY) And I'm sorry. I meant those to be the same thing. The submitted billable charges are not meant to reflect what a patient with the Palmquists' insurance would pay after their insurer negotiates rates and the insurer takes on a portion of the charges and then the patients pay the remainder.

136

MR. PARKER: I object as to form.

A Ms. Paley, I think it's speculative because there's so many nuances in health insurance and there's a lot of variables. And I've previously been instructed by a judge not to discuss insurance in my sworn testimony, specifically at trial. So I'm not really sure how much I can share with my thought process other than what we've already stated, UCR80 billable charges.

If a patient had no health insurance and they want to pay cash for procedures, these are the reasonable, usual and customary fees that would be self-pay options, but insurance is variable on numerous levels.

Q (BY MS. PALEY) Okay. And we're not in front of that judge. So here, you know, I get to ask questions. You get to answer them.

A Okay. I wasn't sure about that then.

Q Yeah. And I think we're actually saying the same thing. Those UCR80s are not meant to be specific to what any one person would pay under any one particular insurance program. Is that --

MR. PARKER: Objection as to form.

A I don't want to speculate about other people. So I could use my health insurance example.

137

I have a $8,000 deductible. And that means I am paying these prices at UCR80 until I meet 8,000. And then my UnitedHealthcare takes over for my little percentage changes.

That's my experience with every other commercial insurer like Blue Cross, Aetna, Cigna in my private practice and hospital billing.

Q (BY MS. PALEY) And in doing the Palmquists', you know, cost analysis here, life care planning cost analysis, you didn't specifically look to say, Okay, with Blue Cross Blue Shield of Texas, what's their deductible? You know, Are they in a high-deductible plan? What are they going to pay? You set aside their insurance, and you just look at the UCR80s or your cost vendor survey, right?

MR. PARKER: Objection as to form.

A Ms. Paley, I outline that starting in Section 6. And what you're describing, I've outlined in detail. And that would be the best practice, tenets, methods, transparent, reproducible methodology to then utilize cost vendor analysis to create a price on his future medical care.

We do not rely upon insurance benefits, Medicaid, Social Security, disability, getting Medicare early or commercial payors. That's not

138

reproducible, transparent methodology that myself, physicians or non-physician life care planners ascribe to, to my knowledge.

Q (BY MS. PALEY) All I was interested in that whole time, trying to get -- and I'm sorry it took me so long to get to it -- is we do not rely upon insurance benefits, Medicaid, Social Security, et cetera. So that's all. I didn't want to, you know, bring up a -- didn't want to send us down a rabbit hole.

MS. PALEY: So let me look at my notes here. Just a second. We're coming close to 11:45, which is what we talked about in terms of a break.

MR. PARKER: Sure.

MS. PALEY: I may be able to get through a little bit more before that.

MR. PARKER: You want to take a break now?

THE DEPONENT: Let's push through. Can you wait 15, 20 minutes to eat?

MR. PARKER: Either way. But if she was at a stopping point and wanted to review her notes, it was getting to the place before the crowd, I thought that maybe advantageous.

THE DEPONENT: Understood.

MS. PALEY: Okay --

139

MR. PARKER: I'll give you the choice.

MS. PALEY: Give me three more minutes and then I think we can be at a somewhat logical stopping point.

MR. PARKER: Okay.

Q (BY MS. PALEY) So the UCR80, that's the 80th percentile of what's submitted as a usual and customary charge, right?

A Generally I think you can describe it as that.

Q Okay. And is that sort of akin to a list price or a sticker price that is before any negotiated discounts between insurers and -- and healthcare providers?

MR. PARKER: Again, object as to form.

A I can't speculate on specific contracts with specific payors and insurance. I can tell you yes, in my private practice, every single payor source, we do have a different contract with, depending on volume, et cetera.

Q (BY MS. PALEY) And that's great. Based upon your private practice experience is very helpful.

And so is it correct that you didn't undertake any efforts to spot-check whether the UCR80

140

rates, how they compared to the negotiated rates that the Palmquists' insurers paid?

MR. PARKER: Objection as to form.

A I don't think I have any ability to, quote, spot-check, end quote, what you're describing.

Q (BY MS. PALEY) Okay. Because you haven't looked at all of their medical billing or the terms of their insurance, right?

MR. PARKER: Objection as to form.

A I don't think it's that simple, Ms. Paley. It would have to be -- I would have to be employed by Blue Cross as an insurance reviewer to actually have all of that information. I have zero access to their specific healthcare insurance plan, benefits, et cetera.

Q (BY MS. PALEY) But even as to what you would have access to via discovery in this case, you haven't looked into the terms of coverage of the Palmquists' insurance, right?

MR. PARKER: Objection as to form.

A I think -- I think I answered that where I don't have access to that and I have not, quote, spot-checked, end quote, these UCR80 versus insurance.

Q (BY MS. PALEY) Okay. We can do -- let's

141

do just a very quick exhibit.
MR. PARKER: Sure.
MS. PALEY: And then I think we can get out.
Q (BY MS. PALEY) I'm going to mark as Exhibit 9 -- these are just a small selection of Ethan's records from Texas Children's.
(Exhibit Number 9 was marked.)
Q (BY MS. PALEY) And if you'll look to Page -- on the bottom right corner, it's 8 -- 7085 to 7086. And do you see that this appears to --
THE VIDEOGRAPHER: Stand by. I think we're good. I'm going to change that mic during lunch.
MS. PALEY: Okay. Sorry. It's every time I reach over the table. Yeah.
Q (BY MS. PALEY) 7085 to 7086, does this appear to be some medical billing related to a spinal puncture that Ethan had in May of '21?
A Yeah. Page 7085, Texas Children's Hospital, it's listed as her mom, Sarah Palmquist first, then Ethan. Admission 5/26/21. And then it has numerous things billable on this page.
Q And about three-quarters of the way down, there's spinal puncture, therapeutic, drain with

142

fluoro or CT guide.
A Yes. I see that.
Q Okay. So let's look at Page 7086. And do you see the section Payments and Adjustments?
A I see.
Q Okay. All right. So before we get to the payments and adjustments, like you said, there are many items listed under Charges. And the total amount is a little north of $17,000; is that right?
A On Page 7086, above that -- yes, 17,000.
Q Okay. And if these --
MR. PARKER: Let me -- I object as to form.
Q (BY MS. PALEY) Okay. If these amounts, if the dollar figures in the amount column in the Charges section, if they were at the UCR80 level, would you include those amount -- and you believed Ethan needed this care going forward, would you include those amounts in your life care plan?
MR. PARKER: Objection as to form.
A Ms. Paley, I don't exactly understand what you're asking me here.
Q (BY MS. PALEY) Well, if -- if Texas Children is billing to Sarah Palmquist at the UCR80 level, just -- you're an expert, so you can make --

143

we can do hypotheticals. You know, assume with me that these are at the UCR80 level. Okay. If that were the case, would you include -- and you believed that Ethan needed this care going forward, would you include these amounts as part of your life care plan --
MS. PALEY: Objection as --
Q (BY MS. PALEY) -- if they were UCR80?
MR. PARKER: Sorry.
MS. PALEY: Go ahead.
MR. PARKER: Objection as to form.
A So I think there's -- there's difficulty with me speculating and doing a hypothetical exercise right now, because I have objective evidence and research in my published life care plan.
With that being said, if we were -- if I was going to price out a spinal tap with anesthesia and the medications and everything all inclusive and the surgery center fee or hospital fee and I used UCR80th percentile, then placement of this ZIP code where they live would include Texas Children's and other hospitals around the area. And the number would be the number that the database gives me.
And I can't speculate if that's exactly the same, different, compared to what you're showing

144

me here in this exhibit.
Q (BY MS. PALEY) And I'm not asking you to say whether these are UCR80 or not. I'm just trying to understand sort of your methodology and say if these were UCR80s --
A Okay.
Q -- if Texas Children billed at UCR80s for their geographical area and you thought that this was care that Ethan needed going forward, say he needed, you know, a spinal tap every other year for some reason -- just this is our hypothetical -- then would you use these amounts in your life care plan, assuming they are UCR80s?
MR. PARKER: Objection as to form.
A I think my answer is the same. I mean, I can't -- I can't do the assumption hypothetical. I don't feel comfortable with that. If -- if a UCR80th percentile charge from my database, which I use, via the methodology, exactly what I did, in the published report matches up exactly this number from this document and exhibit, then that matches up. But there's no way I would be able to postulate if it is or is not the same number.
Q (BY MS. PALEY) And I'm not asking you to postulate. I'm just saying you're an expert. So I

145

can ask you hypothetical questions.
A Okay.
Q That's the way it works. And I'm just saying, if these are UCR80s, you'd use them, right?
Assume with me they're UCR80s. You'd use them in your life care planning, right?
MR. PARKER: Objection as to form.
A So it's not always specific UCR80 either. If there was a specific vendor, Texas Children's Hospital, that provided us with an upfront cost of specific charges, then I could also use in my life care plan, as I explained, in the methodology a specific location, vendor cost for whatever specific future medical requirement it is.
Q (BY MS. PALEY) I understand, sir.
A Okay.
Q But what I'm saying is, in the instances where you use these UCR80s -- assume these are UCR80s -- I think this is pretty -- this is like just a little quick threshold question. You would use them, right? If these accurately reflected UCR80s, you would use them?
MR. PARKER: Objection as to form.
Q (BY MS. PALEY) Okay. Let's -- I'm sorry. Go ahead.

146

A I think I've answered it. That -- my best answer is what I've been stating, because I'm a little bit, again, confused on hypotheticals and postulations and assumptions. And I don't want to misspeak regarding what you're asking me.
Q Okay. Let's look at the Payments and Adjustments section. You see that these are -- there are three Blue Cross Blue Shield insurance payments, correct?
A Okay. So same page, date, 6/3, 6/25, 6/30, all 2021, I see three line items, insurance payments.
Q Okay. And those are like around $8,000 or so out of the 17.
Do you -- if you were using UCR80s or the amounts charged by a specific healthcare provider that the Palmquists wanted Ethan to go to, your -- your life care plan wouldn't make any effort to like reduce the life care plan projected amount by what this Texas Blue Cross Blue Shield payment would be?
MR. PARKER: Objection as to form.
A Right. I'm not understanding how I would reduce the Blue Cross Blue Shield Texas payments. I don't understand your question.
Q (BY MS. PALEY) All I'm asking -- okay.

147

Do you see there's an administrative write-off? It doesn't say -- it doesn't say "Insurance," it says "Account." Last entry.
A I see that, yes.
Q Okay. Your life care plans wouldn't reduce the life care plan projected amount by any kind of noninsurance-related administrative write-offs, would they?
MR. PARKER: Objection as to form.
A So that would not be the methodology that we ascribe to as life care planners, physicians or non-physicians for completion of this, kind of for those reasons that I alluded to earlier on access to healthcare, benefits of healthcare, specific details of Ethan Palmquist is a minor and his parents' employability, insurance benefits, et cetera.
Q (BY MS. PALEY) Okay. So the sort of Payments and Adjustments section of something like this is -- would have no relevance to your life care planning practice. Is that fair enough?
MR. PARKER: Objection -- objection as to form.
A The methodology and the process is not including these things that you're describing.
Q (BY MS. PALEY) Okay. That's all.

148

MS. PALEY: I think -- give me one second -- this is probably a good breaking point.
Okay. Let's take our break.
MR. PARKER: Great.
THE VIDEOGRAPHER: The time is 11:47. We're off the record.
(Lunch recess from 11:47 a.m. to 12:57 p.m.)
THE VIDEOGRAPHER: The time is 12:56. We're now back on the record.
Q (BY MS. PALEY) Okay. Welcome back, Doctor. I want to talk a little bit about your methodology, on Page 75 of your report, to the extent that will help guide the conversation.
A Okay. I'm there.
Q Okay. I want to talk about the survey method, the survey method, the sort of bullet point 1 or Item Number 1 that you have. This is where the -- if the family has a specified caregiver or provider, you use the pricing from that provider; is that correct?
A That an example, yes.
Q Okay. Do you make any effort to determine whether the provider's charges are reasonable or aligned with something like a UCR80?

149

A Well, the effort is based upon my experience looking at charges. And then I think in this specific instance, with like Avondale House, there were not a lot of other options I could price out in that specific geographical area.

Q But generally, in terms of how you apply this cost methodology -- methodology, this cost analysis, do you make an effort to crosscheck the family's provider of choice against other similar options, if available?

A Specifically, yes. Especially in this situation. I was able to basically do a Google search and try to look at things within a hundred-mile radius that would be comparable. And I think I found things in Atlanta and New Jersey, Dallas. So nothing close.

Q Are you speaking specifically about Avondale House?

A Yes.

Q Okay. Do you make any effort to assess the quality of care being provided by the provider chosen by the family?

A Help me understand which provider or what you mean specifically.

Q In general, when -- under Section 6.1.1.1

150

of your survey method, when a family has a chosen provider for care, I know you used that provider's costs as part of your survey methodology. Before using that provider's cost, do you make an independent assessment of the quality of care given by that provider?

A In this life care plan, I think the only applicable future medical recommendation is at Avondale House, and I reviewed their website. And I did speak with Dr. Lisa Settles briefly about that. That would be the extent of my review of that specific vendor.

Q And I reviewed their website too. I didn't see any cost information on it.

How did you get the cost information from Avondale House?

A I delegated to my staff. I asked them on the phone to call them. And these are the potential three options. Please get the number and report back.

Q And here it was the potential one option, right, Avondale House?

A Yes.

Q Okay. Survey Method 2, in the absence of specific providers being specified, this is where the

151

UCR80 comes into play, correct?

A Yes.

Q Okay. So 80 and UCR80 stands for 80th percentile; is that right?

A Yes.

Q So just by definition, the 80th percentile is above the average or the mean, right?

A It's not quite like that. It's defined as 80 percent of all charges submitted. But the average or the mean would be closer to 80 percent if charges are higher compared to those 20 percent charges.

So I can't a hundred percent say average or mean.

Q So -- but it is certainly higher than the 50th percentile, correct?

A It's not -- the 50th percentile number, in my opinion, is higher. It's, again, the conglomerate of the billable charges of 80 percent in that geographical region, are this average number. So it may or may not be compared to 50 percent of those potential care options in that same area.

Am I answering your question?

Q So if you -- just to make sure. I mean, as percent -- percentiles, you take the care providers, you array them -- not you, but Context 4

152

Care arrays them from lowest to highest, and then the 80th percentile would be along that array from lowest to highest, the one at approximately the -- you know, if you have a hundred care providers, it would be the one at the 80th highest price; is that right? Just how math works.

A In general, that's my understanding. I don't think it's that simple, because it's taking all of those billable charges and creating that average to get to the 80th percentile billable charges, is my understanding.

Q Okay.

A It's not saying this is the 80th most expensive price, period.

Q Okay. And we can look at what Context 4 Care says about the 80th percentile if we need any clarification, right?

A (Nodded head.)

Q Okay. But you just -- you don't use a mean or, you know, an arithmetic average for your price?

A That's correct.

Q Okay. If you said to Physician Life Care Planning, Hey, I want to use the 50th percentile in my life care plans, would they say, Sir, Doctor, we

153

are not working together anymore?
A That's a theoretical question that's never been addressed. So I can't answer that.
Q And you -- in your discussion of physician life -- or in your learning about Physician Life Care Planning, have you ever -- strike that.
You received a UCR data from the Context 4 Healthcare organization?
A Correct.
Q Is this an organization that you trust?
A I do.
Q Had you heard about them before you started working for -- doing projects for Physician Life Care Planning?
A Maybe briefly in residency, but not in the detail of how I demonstrate this cost analysis today.
Q Okay. And their -- is part of what makes their data reliable, they're using a very large database?
A I would agree.
Q Okay. And that size gives -- well, strike that.
Large samples can help minimize the effects of outliers; is that right?
A Generally I think so.

154

Q Okay. And UCR amounts -- usual, customary and reasonable; is that what it stands for?
A That's correct.
Q So their amount -- sorry. They're the fees that doctors list on invoices to say patients or insurers, if they're submitting things to insurers, correct?
A I'm sorry, can you just maybe even slow down one more time exactly what you're asking me.
Q Sure. A usual, customary and reasonable amount, UCR, would be what is submitted on a medical invoice, correct?
A In general, it could be that. But we're not sure -- I'm not sure if you mean submitted to the patient or insurance or self-pay option, et cetera.
Q Okay. Well, let's -- let's just -- I want to move past this pretty quickly.
A Yes.
MS. PALEY: Are we on Exhibit 9 -- 10? I apologize, do you --
MR. PARKER: I think we're on 10.
MS. PALEY: Okay.
MR. PARKER: 9 is last up on my deck.
MS. PALEY: Okay. So I'll do this as Exhibit 10.

155

(Exhibit Number 10 was marked.)
Q (BY MS. PALEY) Let's just look at this quickly. I'm going to avoid stepping up and ruining the next mic. Okay. Does this appear to be a document from Context 4 Healthcare?
A Yes, ma'am.
Q And it says, Usual, customary and reasonable healthcare fee data?
A Yes.
Q Okay. Could you turn to Page 2.
A Yes.
Q And the left column, penultimate paragraph, in the last sentence there. It says, Our UCR data offerings make certain that payors have the most accurate and comprehensive fee information necessary --
THE REPORTER: Okay. You have to slow down, I'm sorry.
MS. PALEY: I'm sorry.
Q (BY MS. PALEY) Our UCR fee data offerings make certain that payors have the most accurate and comprehensive fee information necessary to reprice claims in today's complex healthcare.
Do you have any disagreement with how Context 4 Healthcare describes their UCRs here?

156

A I've never actually read that specific sentence before on their website. I have no reason to disagree what they're publishing here on this four-page Exhibit 10 summary that you've presented. Yes.
Q Okay. And on the Page 2, top right column, it says, Billions of healthcare procedure charges are collected semiannually at the provider level before the claims are ever touched by the payor.
And is that part of what makes their data reliable to you, billions of claims?
A Yes. As kind of we touch on, 77 and Page 78 in my life care plan, why it's the largest database and reliable with over 1 billion claims.
Q And these claims are -- it's, quote, Before the claims are ever touched by the payor.
What would you understand that to mean?
A What we were discussing previously. If there's a billed charge with a set fee schedule, depending on specific insurance or healthcare access options, there may or may not be -- may or may not be, I apologize -- a fee reduction or set contractual agreement with the health insurance and whatever provider is billing for whatever hospital-based

157

treatment, office-based treatment, et cetera, imaging studies.

Q Okay. And in the third bullet point on this Page 2, it says, Context's UCR fee data is arrayed in percentiles from the 25th through the 95th, giving you the ultimate in flexibility.

Have you ever taken a look to see just what other percentiles are available through Context 4 Healthcare?

A I have seen numbers from 40 to 80 percent. And our methodology for 80 percent is sort of explained in this report. I'm happy to dive into that, if needed.

Q And in your practice, do you have any sense of what -- like on average --

MS. PALEY: And if we need to take a break for water -- okay.

Q (BY MS. PALEY) In your practice, do you have a sense of what percentage, on average, of a billed amount would be actually collected?

A Are you asking me in my private practice?

Q In your private practice, yeah.

A It's extremely variable on the payor. So we collect a hundred percent of self-pay if we're out of network for a certain insurance company. And then

158

it just depends on, again, the set contracts for procedures and office visits, along with the type of procedure.

So I get pretty close to that 80 to a hundred percent mark for like single-level spine procedures. But if I do a second-level and third-level at the same time, I'm getting less each level at the same time during the procedure as the example I'm most used to, which would be spine injections, spine procedures.

Q Okay. And so if you don't have a -- let's look back at your report. We were on Page 75 talking about your methodology. In the absence of a specified care provider from the family or where UCR data isn't available, then you turn to essentially a phone and internet survey method; is that correct?

A Yes.

Q Now, the report here says that you use at least three providers.

It's actually at most three providers, isn't it?

A No. At times it's been more, and at times we can't get three so it's been just one, depending on the specific nuance of what it is.

Q Are there any cases with Ethan's life care plan where you have more than three providers?

159

A I'm sorry, just so I understand. When you say "providers," you mean specifically the physician services, so actual healthcare providers? Or anything?

Q I mean any time where you're using this sort of third -- third paragraph of your methodology to source data. When you're using that, you know, a phone survey, internet survey.

A Yeah.

Q Are there any times when you use more than three providers in Ethan's life care plan?

A So with the medicines, I'm averaging generic and brand name. So there can be more than three data points that then are averaged. So three pharmacies, each pharmacy, brand, generic, that's six data points for that specific providers that you're mentioning. Other than that, I don't think I have any more than three.

Q And for some of them, is it as little as one? For instance, the CBD/THC provider in the medicines.

A I believe that was the only option for him for that, based upon the medical need and the environment in Texas per the prescribing physician,

160

Dr. Rotenberg.

Q Okay. So essentially, there were not additional -- strike that.

I get what you're saying.

Now, are you offering the opinion -- the opinion from a statistical perspective, that averaging a sample from three providers will lead to a reliable estimate of average prices in -- for a service in a geographical region?

A Yes.

Q Okay. How did you identify the providers for, say, you know, pediatric dentistry? We'll bring that up as an example. How did you specifically identify the providers that you surveyed?

A This was delegated to my staff to start with his specific ZIP code in Pearland and then look at the specific options for pediatric dentists. And then based upon who answered the phone and provided information with that geographical reference, once we have three, we document three and then that's what I published in my report.

Q Okay. Did you provide any guidance or does anyone at PLCP -- sorry, PLCP, provide any guidance to these folks to make the phone calls about finding providers --

161

MR. PARKER: Bless you.
Q (BY MS. PALEY) -- who are close to the Palmquists' home? I know you mentioned Pearland. But do you try to find three providers that are close to the Palmquists' home?
A Yes. So I determine a hundred-mile radius from their -- their actual address to give us enough access to healthcare. And so that's the first direction. The second direction is, what can we find in this specific subspecialty, pediatric dentistry, close to home? And then that's where these three different options came from.
Q And the Palmquists live in the Houston, area, right?
A Houston suburb. I believe the city is Pearland.
Q Okay. And a hundred miles away from Houston is -- a hundred-mile radius is quite far, isn't it? Lake Tejas I believe is about 98 miles, Google told me, from Houston. Are -- do you --
MS. PALEY: Charlie's looking at me.
MR. PARKER: Well, I apologize, but the hundred-mile radius from Pearland would encompass the greater Houston area. And that's where all the providers are coming from.

162

Q (BY MS. PALEY) But the hund- -- let's strike that, and I'll start again.
100 miles will take you far beyond the metro Houston area, right? If you're using a hundred-mile radius from Pearland?
A Typically, it could be a hundred miles I think all the way to the north end of what's The Woodlands, perhaps. Because they're on the south end of Houston, in their suburbs.
Q And did you make any attempt or provide guidance to the folks who did do these phone calls to find providers who were close to each other in any way?
A Close to each other. Not necessarily close to each other. But we start with their location, the Palmquists' family home, and then work out until we're able to find the specific vendors or providers I'm recommending.
Q And just -- I really want to understand this process.
A Okay.
Q Do you -- how do you find those providers? Is it a phonebook? Is it a Google map that shows you -- you know, you type in pediatric dentistry, and it shows you all the providers in an area, then you

163

can zoom out? How do you find these people to call?
A We have a running list in the company, because there's been over a decade of this work in Texas. And so there's a lot of these providers already on that list. And then they verify with my geographical zip or a hundred-mile radius call, access, confirm and then present to me, and I approve or refute.
Q Who puts together that list?
A It's a running list in the company. So it's all of the different vendors and team members and case managers over the last decade, plus.
Q How often is that list updated?
A I don't know.
Q Is there any effort to make sure that that list is comprehensive to include all providers in the greater Houston area?
A So that's kind of where the phone surveys come in, to make sure that those providers are still available, practicing, et cetera. So I guess that's how it would be updated. Because as we're doing life care plans, we have to actually put in the specific vendor for each plan.
Q Now, see, you may be able to identify if an office is closed. But how do you make sure to

164

affirmatively identify new offices that have opened or new locations for offices that have expanded? You know, you have two offices.
A Uh-huh.
Q How -- how is that list maintained to be an accurate representation of the care providers in a particular field in the greater Houston area?
A I'm not exactly sure, because I don't do that type of rote task with that -- maintaining of that list in the company.
Q Okay. And so this list is available for you or for other Physician Life Care Planners who are working with PLCP whenever putting together life care plans that involve someone in the Houston area?
A I typically don't access the list because that's what our staff is trained to do with this vendor survey. And so it's my understanding that it is available with either the employees from the company or the physician experts that are working with the company, then create kind of this type of cost data, vendor survey example.
Q And when putting together this survey, did you endeavor to include the Palmquists' current provider even if they hadn't specifically said, you know, We absolutely want to stay with this pediatric

165

dentist, for example?
A I wasn't informed about that specific patient preference from the mother, Dr. Sarah, or father, Mr. Grant. So there wasn't a specific effort to do that.
Q Okay. So the -- there's no slot held for the current provider, you know, as one of the three? Just generally.
A Are we only speaking about the pediatric dentist?
Q No. Just as a general methodology. I'm trying to -- when I say "pediatric dentist," I'm just trying to use as an example. But when you call for any -- any sort of care provider where you're doing a survey, if the family hasn't specified that they want to keep their current provider -- they haven't said anything bad about them; they just haven't specified -- do you include the current provider as one of the three options?
A I mean, that's possible in the methodology, specifically in this plan. It's only dentists and pediatric dentists that we called on, because the other medical physicians are part of the UCR80 database. So it's only addressing the two dentists, depending on the age.

166

Q Well, I'm actually not just speaking about the medical providers. I'm also speaking about nursing and home healthcare and pharmacies. For whatever providers where you did a -- where PLCP, on your behalf, conducted a phone survey --
A Uh-huh.
Q -- was there any effort to include the Palmquists' current provider as one of the three options? I'm just -- I just want to know what the process is.
A It is an option if they tell me that. But that wasn't communicated.
Q Okay.
A And I don't actually think we have that ability, because of my understanding of what his care is currently. And then the methodology to make it more simplified with UCR80 and then the specific pharmacies are listed and, you know, everything else moving into the next future medical requirements sections are listed as well.
Q Oh, and I understand who you called. I just want to understand the process for deciding who to call. That's all.
So I know that you don't do the rote, you know, calling of care providers, pharmacies, home

167

health agencies, what have you. But do you know what instructions those who -- are given to those who specifically do do those calls? Do they have a script that they follow?
A I'm not sure if they have a script. The instructions are based upon their training in the company as well as my instructions. And basically they call to ask about the specific type of follow-up office visit, medication, or for therapy. The hour, 60 minutes is what -- you know, what I'm having on most of my therapy on behalf of Physician Life Care Planning. And then if there's more information, it's on behalf of Dr. Hyzy.
And then typically most different vendors are pretty easy to work with to get that information, and then we present and publish it.
Q So is it -- but is the request, say, I'd like your usual and customary cost? Or is it, I'd like the cost that you would give to a cash payor? Or is it something else? What's the specific request for the dollars? How do you -- how is it described to the vendors?
A That's a good question. I think, you know, the UCR80 data is only being pulled from Context 4 Healthcare. So when we're calling specific

168

vendors, could we use Page 92 as an example? Page 92 is occupational therapy and speech therapy. And so I think each case manager and vendor team member, they all have a little bit different vernacular. But on Page 92, they're -- I understand that they've been taught to ask for the self-pay cost or the cash rate for these types of evaluations.
Because, again, I cannot rely upon commercial insurance, Medicare, Medicaid, disability. There are so many variables. We have to have a consistent methodology of, What does it cost for the self-pay option? And then that's how we -- like on Page 92, we'll have three vendors, get the numbers, average, and that's what I'm using for my total cost analysis in the average.
Q Okay. Now, the life care plan that you've prepared here, it has a span of approximately 70 years. Have you prepared any other life care plans that have time horizon --
(A discussion was held off the record.)
Q (BY MS. PALEY) So I'll reread the last question.
Have you ever prepared another life care plan that has a span of, you know, about 70 years, as long as Ethan?

169

A Yes.
Q How many of those?
A Those would be the other pediatric ones we mentioned earlier. And somewhere around Ethan's age, I think I have two or three that would be below the age of seven. So then that would lead to an additional 70 years, more or less, of a life expectancy as well in those cases.
Q Okay. And in Ethan's plan, for each of the medications that he's on, you predict use for the duration of his lifetime, correct? For each of the medications that you list in this life care plan.
A Can you just give me a second to reference that?
Q Sure.
A Okay. I am on Page 154.
Q Yes. And so for each of the --
Medications 1 through 3 are different doses of the same CBD/THC tincture, correct?
A That is correct. And that does total 70 years. And then the remainder of the medications are all for the remainder of his life span of 70 years.
Q So I'm just trying to understand, how can you, to a reasonable degree of medical certainty,

170

given all the complications of Ethan's care, emerging medicine, assert that, you know, 69, 70 years from now, Ethan will more likely than not need a specific medication, a specific number of times a day?
A Those are great questions. And we touched on speaking to the treating gastroenterologist and neurologist on these questions. GI medicines, seizure medicines, which include the CBD. And we're all three of us in agreement that they're recommended for life. The specific dose increase of the CBD is based upon his age and his weight's increasing. So that then leads me to have the higher dose, which I think you see as Item Number 3.
And then some of the other medicines -- Catapres, Lamictal, Risperdal, Intuniv -- given those medicines for not only seizures but other behavioral problems, those also were discussed, Dr. Rotenberg and I, and for life. And I would agree. And then I use his current regimen and frequency, then discussed with the doctors and what I think his life expectancy. Then that's how essentially we have the summary chart 154 on the 70 years of duration.
Q Did you undertake any independent analysis of the doses that Ethan is currently receiving for each of these medications compared to the doses that

171

are indicated in the prescribing information for these medications for a child of Ethan's size and age?
A I did not review specifically the prescribing information. I don't think that exists for 1 through 3. 4 through 10, I'm pretty familiar with these. I did review the specific doses. That's in my examination section. And I may have reviewed, on like Medscape or Drugs.com, dosing and frequency to make sure I heard Sarah right, I documented, dictated it right and there wasn't a transcription error, right? Like 0.4 milligrams versus 400 milligrams. So I think I did briefly do that reference, but I didn't see any alarm because I'm pretty familiar with the majority of these medicines.
Q And when you say "alarm," did that mean alarm as in didn't see anything where the dose seemed too high?
A It could be too high or, again, you know, sometimes when you hand-fill out or type something 4 could turn into 40, right? Things like that. So that would be an alarm to me is that, I'm used to this medicine being 4 milligrams, now it's 400.
An example, HUMIRA, if they listed HUMIRA daily, I know it's not daily. So that would be

172

another alarm. I need to verify then current dosing via medical records or treatment providers, et cetera.
Q And did you specifically analyze whether any of Ethan's dosing is below what is recommended by the prescribing information?
MR. PARKER: Object as to form of that.
A I think I answered that. I didn't review the specific --
Q (BY MS. PALEY) Okay.
A -- prescribing information. That's typically a few pages per drug based upon multiple factors. So the general doses I think I reviewed consistent with my experience and what I did look at plus the medical records describing doses -- dosages of prescribed medications.
Q Okay. Give me just a moment.
A Yes. I don't think I answered one of your questions earlier. I'm sorry.
Q Let's -- I want to use the pediatric dentist as an example again to ask a question. When you're deciding the frequency with which Ethan would need certain types of care, did you specifically evaluate how frequently a neurotypical person would use -- need that type of care and subtract it from

173

what you thought Ethan might need to determine the difference or the delta between Ethan's needs and what a neurotypical person may need?

A So in general, that is part of my methodology. So pediatric dentist I think is specifically what you mentioned, right?

Q Yeah. And we have for three times a year, I believe we have.

A You know, two to three times a year is pretty standard, in my experience with my children or any other child. And specifically with his neurocognitive issues and his inability to do self-care, I decided on three to make sure that he has enough care to prevent complications, right? He doesn't get any care, he doesn't brush his teeth, the next thing you know, we have a tooth infection, extraction, et cetera. So I think three was extremely conservative.

I very well could have put, you know, closer to five on that. So that's kind of how I use my methodology, experience, training and the current observation or exam of the child and the family.

Q Okay. But in putting three, it's not that you were thinking, He needs five, but most kids get two, so I'm going to take five minus two and say the

174

difference is, because of his -- you know, because of his illnesses, he needs three extra trips to the dentist? That wasn't the process, right?

A That's not the process.

Q Okay.

A His parents do a good job of attempting to help him. But I don't think he has the best hygiene. Clearly he's bitten nonfood items. He's eaten dirt. So I think three a year is pretty conservative to have that preventative model of care to make sure he doesn't have complications regarding his dentition.

Q And for other types of care, say, adult dentistry, trips to the pediatrician, trips to the general practitioner as an adult, was it the same process? You just assessed what you thought might be reasonable for Ethan but didn't then subtract the number of visits that a neurotypical person might have to get your final frequency?

A Those are good questions. So, you know, the whole methodology has -- has all that intake, what's the history, observation. That's very, very important. How many visits is he currently seeing per year, these doctors? Then the projection, when he becomes an adult -- which we can call 18 or 21, I used 21 in this instance, because most pediatric

175

dentists and pediatricians will see patients to age 21 in my experience. And then, yes, in addition to one primary care doctor visit a year, I'm recommending these additional three visits a year, right, so he has a quarterback to help him with all these different things.

And then the specific frequency on other things, like the neurologist, gastroenterologist, you know, those are more based upon medication management, laboratory. You have to follow up with patients four times a year is still pretty conservative. Every three months you're seeing a specialist. So that's the general methodology, based upon my experience and then Ethan's specific situation today.

Q In selecting the care providers who are listed in any of the surveys, did anyone make an analysis of whether it was likely that the Palmquists might go to that specific care provider, given, say, the distance from the home and other factors?

A Not yet. That's always after I finalize my plan and provide it to the law firm and the family as kind of what we discussed initially as an outline for the family and case management. Then they can have those discussions. And then of course if we

176

need to make amendments, supplements down the road, we can do that.

Q So within your life care plan here, if some of those providers were 39, 40 miles away from the Palmquists' home, that would be -- under your methodology, that would be okay?

A That would be okay, especially given some of the unique specialists that I think will benefit him and his family. And the more subspecialized we go in medicine, the less of us there are, right? So that means there's less density in a given metropolitan.

Q But what if it's just like a dentist or a pediatrician? Would you still be okay with it being, you know, 39, 40 miles away from the Palmquists' home?

A Again, it depends on the patient preference. And then they're going to use my examples as a guide. Some dentists may not be comfortable with an adult with special needs, and they may not have that experience or certain things for twilight sedation or nitrous in their office, et cetera.

And so, again, that's given to the patient for them to choose. I can't have a back and forth

177

with the family in the middle of my production. That's not the methodology. I don't think that's focused, objective and transparent.

Q And you actually brought up a good question -- or a good issue. Some providers may not be comfortable providing care to a special needs child or a special needs adult.

A Uh-huh.

Q In doing the survey, did the folks who made the calls to the care providers specifically indicate that they were asking about whether -- or what the price of care would be for a child or an adult with Ethan's profile?

A All pediatric dentists are trained in this, in my experience, and have typically office sedation or surgery center privileges to do that. So that -- that was not inquired. The adult dentist would be the only one I'm thinking that in your question is applicable. And no, we're not providing the nuances of a diagnosis to the vendor when we're asking for, you know, the average 40-minute consult self-pay fee.

Q Okay. Thank you.

And let's see. Just sticking on -- let's keep with our pediatric dentist for a moment. Let's

178

look at Pages 81 to 83. And, again, this is just an example. I think probably because it was the -- one of the first ones -- yeah. It's the first one on your cost vendor survey.

With the pediatric dentists on Page 81 of your report --

A Yes.

Q -- the costs vary from $99 to $350; is that right?

A That's what I see, yes, ma'am.

Q And when there's about that 3.5X, you know, three and a half times difference between the costs, did the folks who made those calls double-check to make sure they were really being quoted prices for the exact same services?

A I don't know if they double-checked as in called them back and asked them the same question twice. So I'm not sure.

Q And when the costs vary this much, you know, about three and a half times, does that ever like raise a red flag for you that perhaps you need a larger sample in order to understand what the real average in the area is?

A Not with this, at all, actually, because three is a very good methodology to average.

179

Especially with non-physician life care planners, they're not always even giving specific vendors. They're just kind of saying it could be 99 up to $400, when I've reviewed others.

And then an example here in the Denver metropolitan is a $300 MRI, and I've seen charges up to 2200; exact same MRI, same machine. It's just different area, different company.

So these variations seem very normal to me, given the experience, the amount of life care plans I've already authored, reviewing lots of data, hospital billing, clinic billing, procedural billing, et cetera.

Q And is there any effort to sort of dig into these particular organizations a little bit and make sure that they provide quality care?

A So, again, if they're a pediatric dentist, they have additional training in pediatrics, and I don't see it necessary to do that. That would be, again, here are options. Once the life care plan is produced, the family or case managers can use that as a guide, and then they could do their own individual research to determine if they would like to move forward with that specific vendor.

Q And does the same apply to all the other

180

vendors who you contacted, not just the pediatric dentists?

A No, ma'am. And I would just say no because the dentist is really the only other one for healthcare provider. The rest of the physicians, psychologists are the more average, conservative, Level III, Level IV consult codes. And then specific testing diagnostics are UCR80 data as well so we didn't call them. And then the pharmacy aspirin are pretty straightforward on their -- their pricing. Moving --

Q Well, actually I think you might have misunderstood because I said for any of these vendors where you used your survey method and called vendors.

A Yeah.

Q So that would include occupational therapy, home healthcare, speech therapy, coverage like that.

A I understand.

Q Visiting nurses. Did you make home health -- did you make any effort to evaluate the quality of care for the various options that you include in your life care plan?

A That's not part of my methodology. And in my experience, they are able to evaluate both adults

181

and children at home. And so I did not feel the need to, again, validate or independently me call them to discuss this. We reserve that for the family or the client or the patient, because we're listing good options and they are able to decide on which vendor they would like to go have that care with.

Q Let's -- let's move on to another care provider as an example where you use the UCR80s. On Page 82, you include a recommendation for a behavioral psychologist, 45 minutes. And then on Page 108, we can see how you operationalize this in terms of duration and frequency of care. Page 108 is probably the more informative one here for our discussion. It's Item 9, behavioral psychologist, 45 minutes.

A Uh-huh.

Q And if I understand this correctly, the recommendation here is that starting now at age 7, Ethan have weekly visits, one visit per week to a behavioral psychologist for the next 14 years. So until he's about 21 years old. Am I reading that right?

A Yes, ma'am.

Q Okay. And did any of Ethan's doctors specifically make this recommendation, either in your

182

conversations with Drs. Krigsman or Rotterman [sic] -- I believe I got that wrong -- or in the medical records?

A I think it's Roten- --

Q Roten- --

A Rotenberg. It's not Rotten. It's Rotenberg, a neurologist. I briefly touched on this with Dr. Rotenberg because he will need that. And then this also I think I discuss with Dr. Lisa Settles, the doctor of psychology, for ongoing behavioral assessments with the behavioral psychologist to optimize his care. And so that's kind of where we have the listing and the frequency here.

Q Okay. Is there any specific discussion of that in your report other than those two lines where you say, I spoke with Drs. Krigsman and Rotenberg and they agreed with me? Is there any other more detailed discussion that provides the rationale for your evaluation here?

A Not with the treating physicians' verbal discussion like doc to doc, peer to peer. Only in explaining the methodology on the future medical requirements, I believe going back to Page 5. And then in my experience when we sit down like this in a

183

deposition is -- is the ability for me to then explain the rationale, given my experience, training and the medical practice side of things.

Q Okay. But the -- the rationale itself is not spelled out in the report somewhere? I didn't miss it?

A That's correct. We don't typically do that in the methodology. That would then make this closer to 400 pages.

Q Okay. And so I can ask you questions here today, but if I just had the report I wouldn't understand necessarily the rationale for any -- any particular form of care or the frequency or duration?

A I think the family would. A general pediatrician would. The treating GI and neurologist would. Other physiatrists or pediatric PM&R doctors would. Non-medical professionals, like attorneys, likely would not. Case managers likely would because they're dealing with that.

Q And how would you specifically -- how did you specifically land upon, you know, 45 minutes for the behavioral psychology meetings? I see it's like -- it's two -- two units. You've got a 30-minute unit and a 15.

A Uh-huh.

184

Q What was your specific rationale for coming up with 45 minutes?

A Typically it's 30, 45 or 60. So 60 minutes is going to be more time. 60 minutes is going to be more expensive. I don't think 30 minutes would be enough to maintain observation and/or the ability to do treatment with him and his parents. So 45 minutes is a conservative option because it's not 60, but it's still enough time for the behavioral psychologist to identify problems and then suggestions, treatments, strategies, homework for the parents, come back, we'll see you next week and reevaluate.

Q And does Ethan currently see a behavioral psychologist?

A I think he has in the past. I'm not sure if he is currently today.

Q And have you found any like literature in the peer-reviewed literature that -- or medical guidelines for treating children with autism that says that, you know, treatment with the behavioral psychologist is -- is understood to be effective in children with Ethan's profile?

A Number one, I don't think there's a lot of children that have the plethora of diagnoses that

185

Ethan has. So there's a paucity of peer-reviewed literature in that space, given the unique case. And there's also, in my opinion, ethical concerns with doing studies on children with these amount of diagnoses.

In general, I think psychologists, general pediatricians and pediatric neurologists would all agree with me on behavioral psychology as an option to help then improve the quality, life and function of his family and Ethan himself.

Q Okay. But is -- is that a no, that you haven't -- you know, you haven't found or cited peer-reviewed literature that supports the idea of having a child with, say, severe autism receive weekly treatments with a behavioral psychologist?

A I haven't been asked to do the peer-reviewed literature search, so I haven't searched for it or found it. So I haven't looked. And so I'm unable to tell you if it exists or not at this time.

Q Okay. Let's just very quickly go through this. This is Exhibit 11.

(Exhibit Number 11 was marked.)

MS. PALEY: Sorry, Charlie. I got it stuck on the back of your iPad.

186

Q (BY MS. PALEY) This is from, you'll see at the bottom left, the Journal of the American Academy of Child and Adolescent Psychiatry.

A Uh-huh.

Q Do you see that?

A Yes.

Q So these are the folks who would include behavioral -- well, psychiatry here, but sort of behavioral care for children or for children and adolescents, right?

A Yes.

Q Okay. And the top of it says, AACAP, American Academy of Child and Adolescent Psychiatry, official action, right?

A Yes. That's what I'm reading.

Q And it's a practice parameter for assessment and treatment of children and adolescents with autism spectrum disorder.

A That's what it says, yes.

Q Okay. Can you turn to Page 244 and 245 of this article.

MR. PARKER: What page again?

MS. PALEY: 244 and 245.

Q (BY MS. PALEY) And do you see on the bottom right of 244, there's a header that says

187

Treatment? Its recommendation for the clinician: Should help the family obtain appropriate, evidence-based and structured educational and behavioral interventions for children with ASD.

Do you have any disagreement with that recommendation?

A Can -- can I have about five minutes to read through this article off the record, please?

Q Sure. I think off the record makes good sense, because then we can open the doors and get a little fresh air in here.

MS. PALEY: Does that work for you, Charlie?

MR. PARKER: Sure. It works.

THE VIDEOGRAPHER: Okay. The time is 1:47, and we are off the record.

(Recess from 1:47 p.m. to 1:59 p.m.)

THE VIDEOGRAPHER: The time is 1:59. We're back on the record.

Q (BY MS. PALEY) Okay. Welcome back, Doctor. Let's look again at Exhibit 11, I believe it is, the AACP official action practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder.

A Yes.

188

Q You just spent a couple minutes looking at this, correct?

A Yes.

Q So before I introduced it to you, you hadn't seen this document?

A Correct.

Q Okay. We are looking at Page 244, right-hand column under Treatment. And there's a recommendation for the clinician should help the family obtain appropriate, evidence-based and structured educational and behavioral interventions for children with ASD.

Would you agree that that's an appropriate recommendation for how a clinician should help the family when a child has ASD?

A Yes.

Q On 245, the section on Treatment and Recommendation Number 4 continues. And do you see we have four sections: Behavioral, communication, educational and other interventions?

A Uh-huh. Yeah.

Q Based on the headers?

In the Behavioral section, this section discusses that ABA, or applied behavioral analysis; is that right?

189

A Behavioral paragraph, opening sentence ABA, yes.
Q Okay. And then the paragraph goes on to discuss sort of some of the evidence that supports the usefulness of ABA and ABA techniques in an academic setting essentially; is that correct?
A Yes.
Q Okay. Do you have any dispute with the recommendations there?
A No.
Q Okay. Section -- the next section is on communication and discusses a speech-language pathologist and treatment with speech-language pathologist.
Do you have any dispute with the recommendations there?
A No.
Q Okay. And then the next section is Educational. And it says, There is a consensus that children with ASD need a structured educational approach with explicit teaching.
Do you have any dispute with that statement?
A No, ma'am.
Q Okay. And then Other Interventions. It

190

says, There is a lack of evidence for most other forms of psychosocial intervention, although cognitive behavioral therapy has shown efficacy for anxiety and anger management in high-functioning youth with ASD.
Does that sentence provide any sort of support for a recommendation of behavioral -- treatment with a behavioral psychologist in children with ASD?
A So cognitive behavioral therapy, in my experience, could be a behavioral psychologist administering the CBT or a speech-language pathologist specifically trained in cognitive behavioral therapy. And so at times, the behavioral psychologist may be involved in testing. And I think that's also on Page 244 of these -- this document, practice parameter, as I'll call it.
Q But this mentions CBT in youths with high functioning -- high-functioning youths with ASD. Ethan is not in the high-functioning category; is that correct?
A I would not put him in the high-functioning at this time.
Q Okay. Do you see -- having spent a few minutes with these practice parameters, do you see

191

any specific recommendations in here that would support a finding that a child of Ethan's profile would benefit from weekly meetings with a behavioral psychologist until, you know, age 21 or so?
A Sure. That's a great question. I think on Page 244 under Recommendation 3, second column to the right, second paragraph from the end, it starts with, Psychological assessment, including measures of cognitive ability and adaptive skills as indicated for treatment planning.
Q Anything else there?
A So that -- that paragraph, when I read that, would -- you know, would also help me understand -- all the way down through that last subheading, Recommendation 3, before we get to treatment Recommendation 4, that would, again, give me an idea about, in general, there is some recommendations here for psychological assessment and not just a master's level psychologist but specifically a behavioral psychologist, as I recommended, that I think is optimal care.
Then I think also everyone that reads my report or hears me testify should understand that I am not doing a prescription for care like a medical guideline or practice parameter. The life care plan

192

is to achieve four clinical objectives, which we outlined in the life care plan.
Q And psychological assessment, that doesn't mean weekly intensive meetings with a behavioral psychologist?
A Well, I think it's up to debate on interpretation. In general, an assessment would be less frequent than -- than once a week, yes. I think, again, my thought process is if we look at the four clinical objectives of the life care plan, then weekly behavioral psychologist is going to help him and the family deal with some of these neurocognitive disorders, which then, again, specifically addresses my four objectives, which is different than a treating physician and a prescription for care.
Q So I'll admit, I struggle a little bit in understanding the difference between what you're recommending and what a prescription for care is. Because it seems --
A Uh-huh.
Q -- that what you're saying here is Ethan needs this. And if I were his treating physician, I would prescribe, you know, this care.
But that isn't what you're saying. And I just -- I want to understand, where is the gap

193

between what you recommend and what would make it a prescription for care. Because there seems to be some gap in here, and I'm just not getting it.

A Sure. Yeah. On Page 252 at the end, I think it's important to also add to this discussion on Page 252 of this article, the very last paragraph before References states parameter limitations. AACAP practice parameters are developed to assist clinicians in psychiatric decision-making, period. These parameters are not intended to define the sole standard of care. As such, parameters should not be deemed incluses -- inclusive -- excuse me -- of all proper methods of care or excluses -- exclusive of other methods of care directed at obtaining the desired results, period. The ultimate judgment regarding the care of particular patients --

THE REPORTER: Okay.

THE DEPONENT: Sorry. I apologize. Do you want me to start over?

THE REPORTER: The ultimate judgment.

A The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family.

MS. PALEY: But -- not to sound -- but

194

move to strike as nonresponsive.

Q (BY MS. PALEY) My question was a little more specific, not about behavioral psychology specifically.

A Okay.

Q But when you talk about your recommendations are not a prescription for care, but you're saying more likely than not Ethan needs these, I'm trying to understand what the difference is between those two things.

A Okay. So I think the prescription for care is when you're managing a patient acutely with four-week, six-week, 12-week follow ups and involving the patient or family, depending on the age and decision-making. And on Page 252 here, it specifies parameter limitations that these are for decision-making, not solely standard of care inclusive or exclusive, now I'm paraphrasing.

Q So is a prescription for care a specific set of recommendations in an acute care setting? You used the word "acute."

A Acute care setting is hospital, skilled nursing, et cetera, or outpatient established care setting. Acute as in less than three months. So you prescribe something and you follow up on that

195

prescription intervention.

I think the global answer here is on Page 1 and 2 initially of my life care plan. My -- my simple goal and what I've been asked to do here is to answer the three basic questions of life care planning to achieve my clinical objectives. And that's the whole premise of the methodology in this plan, which is different than I prescribe somebody, post acquired brain injury, TBI, cognitive behavioral therapy, and I want it two to three times a week for six weeks, report back at six weeks and then we may or may not change medicines or intervention. That's a prescription for care.

But the life care plan is not a prescription for care.

Q Can the life care plan, by definition, not be a prescription for care because it has a 70-year horizon?

A No. It's I think by Definition Number 1 not a prescription for care because we haven't established a therapeutic relationship as a patient/physician. Number 2, it's a guide for family case managers, providers and others. And then Number 3, with our life care plans, I'm not following up at my four-week, six-week, eight-week, 12-week

196

intervals, which is very, very common when you're actively treating a patient or prescribing care when you have a therapeutic relationship established.

Q If you did have a therapeutic relationship established with Ethan and you were talking with his parents, would you say, Hey, I -- I think this is precisely the care he needs for the next 70 years of his life?

A That's generally what I would engage in an open discussion with them, with the feedback on their thoughts. This is what I recommend, the behavioral therapy, the behavioral psychology, what are your thoughts. And if I was engaged in a therapeutic relationship, we have the informed decision-making together process and then the prescription for care.

Q So if -- if Ethan's parents were, you know, awarded a damages amount that was based on, you know, Dr. Davenport's extrapolation of your nominal care figures -- he does a present value analysis -- if Ethan's family were awarded the amount requested in the present value analysis and then his family decided not to pursue some of this care or to pursue a little bit less of the care -- say, behavioral psychologist every other week -- then the result would be that they would -- they would keep whatever

197

that -- they would keep whatever that award was and just not have to spend it on the, you know --

MR. PARKER: Objection as to form.

Q (BY MS. PALEY) -- care.

A I -- I think I understand your question, but I really don't want to speculate on what may or may not happen or may or may not do. I think the best way to adjudicate this specific recommendation is, you know, I have a follow-up with the family and then produce an amendment in the future, because -- and then we'll have the opportunity to discuss the specific care. And then ultimately it wouldn't be for me to decide that care. It's for the parents and family to decide that care as well.

Q Okay. So is this sort of an outer bound and they may decide that they need less, but you've tried to provide this sort of most robust or complete set of recommendations possible?

A Definitely not complete and robust, because there's definitely things that I didn't consider adding for more cost or duration. But I would describe it, again, as preventative, optimal for the three main questions that we answer as a life care planner to achieve then the objectives.

And that's why this document is lengthy

198

and it's not a prescription for care.

Q So would you agree that when assessing future care needs, it's inappropriate to simply extrapolate out current patterns in medical care or medications or medication use for the remainder of a person life, try to make some adjustments -- it's appropriate to make adjustments over time based on an understanding of how their needs may change?

MR. PARKER: Objection as to form.

A Can you just reread the question, please.

Q (BY MS. PALEY) Sure. Would you agree that in attempting to assess future care needs, it's inappropriate to simply extrapolate out current patterns of medical care or medication use for the remainder of a person's life?

MR. PARKER: Objection as to form.

A No. I think that's an incorrect statement because, again, it's this totality of information in this very long document. Plus, then you also have to consider what our experience is as these children become adults and then we care for them as adults and the training of myself, our board certification for future care needs.

And so it is appropriate, in my opinion, to utilize current medication frequencies, current

199

care and anticipate the future care, which is in addition to what he currently has and then what follows is, is my report.

Q You said, Our board certifications for future care needs. What board certification is that?

A I'm sorry, I might have been speaking too fast. So physical medicine and rehabilitation specialists like myself and our board certification in that specialty. So we have significant amount of training. It's four years of residency directly in this space. Functional rehabilitation, medicine, surgery, procedures of disabilities, neurological system, very applicable to Ethan, how he transitions into adulthood for, what I'm recommending, approximately 70 years.

Q Well, would you agree that the fact that a person is taking a particular medication at a given time, at the time a life care plan is formed, does not mean that he or she will be required to take that same medication for the rest of his or her life?

A No. I do not agree with that statement because we can't just use a general "a person" or "a patient." Specifically for Ethan, I did my due diligence speaking to the treating physicians and garnered recommendations on the duration of the main

200

medications being prescribed. And so the treating physicians were recommending those medications for the rest of his life.

I think also in addition it's important to note that there may be a new prescription brand name in the future at a higher cost. Sometimes we may change, obviously, the medications years from now; but that, then, requires new data years from now that I don't have today. And so this allows us to get a number on the total medication cost based upon the current situation at hand, the treating physicians, their recommendations and his current medications.

Q My question was actually just a little bit narrower. And I'm going to ask it again using a slightly different -- like pronouns, I guess maybe.

The fact that the subject is taking a particular medication at the time of the interview and examination for a life care plan does not mean that the subject will be required to take the same medication for the rest of his or her life. Do you agree with that?

A Again, that may be applicable for some patients. But in my review and production of this life care plan with Ethan and speaking with the treating physicians, I would not agree that statement

201

is as black and white applicable for Ethan today.
Q Okay. I was just speaking more generally. I wanted to understand your -- your approach to a certain -- you know, to the methodology of putting together a life care plan.
Would you agree that when formulating recommendations for future medications, a physician life care planner should ensure that a strong medical rationale for each particular medication exists?
A Yes. I think that we've covered that with the treating physicians, as well as my ability to make that independent analysis given my qualifications.
Q Okay. Let's talk a little bit about some of the medications that you include in your life care plan. And I hope we can move through these relatively quickly. That's my aim.
Look at your life care plan, Page 85. And do you see Page 85 is where you begin your cost survey for medications?
A Yes, ma'am. I'm there.
Q Okay. And that runs through Page 90. All right. A couple of questions about the process that you used or the methodology that you used here. I see that for -- for medications other than the

202

CBD/THC tincture, you included three pharmacies and in some instances a brand and a generic from each of the three pharmacies.
So question for you: If Ethan's family always used generic prescription medications when available -- I'm not saying they did. But if they did, would that have any effect on the cost estimate in your life care plan?
A I just don't think that is reasonable to -- to change the cost analysis. It's speculative and could be misleading, because medication costs may change depending on access to healthcare insurance. Or, again, there might be a brand name option only.
So if -- if a patient chose to only do that, then they may have less expense regarding generic, but that's not the methodology that I ascribe to or reproduce or transparent. So that's kind of where these generic brand name averages will come from.
Q Well, I think that wasn't quite an answer to my question. The question was very simple, yes or no. If Ethan's family always used a generic medication when generics were available, would that have any effect on the estimates in your life care plan? The answer may be no, but I just want to

203

understand.
A I -- you know, I have a difficult time answering that simply yes or no because I think it's misleading and speculative because we can't -- we can't do that to a family or a patient because there are so many other factors involved. And at times pharmacies don't even have generic options, and they have brand name only because of supply chain problems, because of formulation differences.
Brand names have a tighter formulation. Generic have 5 percent fluff room on the specific drug. So sometimes even generics don't work as well as the brand name. So I can't agree with that because it's not something that is in my methodology or I think is the best optimal care for Ethan.
Q So I'm very specifically asking you not what you think is appropriate or what we should do to the family. I'm asking you if Sarah Palmquist and Grant Palmquist said to you, We always use generics if a generic is available, if they said that, would that affect your process? It sounds like the answer is no. But I just want to understand.
A So --
Q If they said, We always use generics, would that affect your process?

204

A So they did not say that to me. And so I think it's a tough, misleading question because we're speculating on if they would or would not. And I think I describe the methodology and process that I go through this first and then it gets presented to the family and then they would have the ability to discuss with whoever they want generic or brand name.
I just can't -- I can't tell you the answer is yes. That's more of a hard no because of everything I've been describing in my answers.
Q So it's a hard no? Is that --
A For all those reasons I outlined previously.
Q Okay. And if one of the prescriptions that Ethan takes is slated to go generic soon, would that have any effect on your cost estimates for the next 70 years?
A Perhaps. Again, it's going to, then, be an average of the brand name and generic. And in my experience, that's very important because we have to have access to the brand names for quality control purposes.
Q Okay. Would it be appropriate to update a life care plan if a major drug -- strike that.
If one of the drugs that Ethan used does

205

go generic in the next, say, year or so, would it be appropriate to update the life care plan to reflect that mix of brand and generic availability?

A I think if the family had that clinical question, I would be available to update that. But I also would have to have -- I would also have to have another clinical reason, most likely, to update that, given the time involved and cost on the family and counsel, law firm and the amount of time it would take me to -- to update a life care plan.

Q So if one of the drugs that Ethan used goes generic, you know, say about a year from now, would that mean that at that point in time your life care plan would not accurately reflect the market prices for that drug?

A I wouldn't agree with that because it still would accurately reflect the market. It just, in addition, there would be potentially a brand name option. And, then, again, there's patient autonomy and choice on using the brand name or generic, or there isn't patient autonomy and it's what the treatment provider is prescribing.

Q But if your methodology is to average brands and generics and if a generic comes onto the market, just -- no judgment, it's just that your life

206

care plan will be out of date at that point because it won't follow your methodology of averaging brands and generics.

MR. PARKER: Objection as to form.

A Again, I think there's the situation that we would consider an amendment or supplement just kind of like here where I say that this was complete at the time, so March 30th, with information at hand. And we can always consider to update it.

It may or may not be clinically significant for the patient and his family.

Q (BY MS. PALEY) And if Ethan's family routinely used the same pharmacies to fill their prescriptions --

A Okay.

Q -- and, again, I'm not saying that they did -- but in your practice for preparing life care plans -- strike that. I'm going to start a little more generally.

In your practice of preparing life care plans, if a family routinely uses the same pharmacies to fill prescriptions, would your cost survey make sure to include those pharmacies as part of your cost survey?

A Potentially, yes, we could include that

207

specific pharmacy. I don't recall asking Dr. Sarah which pharmacy she used. And in general, in my experience, the big commercial providers like the Krogers and Walgreens and CVS all have relatively similar prices. And so to get averages, I think it's more important to get at least those three pharmacies to then average.

Q And if Ethan's family routinely -- sorry, strike that.

If a -- in your methodology for putting together life care plans, if a family routinely used online pharmacies to fill prescriptions, would you make sure to include those online pharmacies as part of your cost survey?

A Yes. I think if we had that discussion upfront on specifically how that was being prescribed and dispensed, I would consider that in the future.

Q Did you -- did you have that discussion with Sarah Palmquist here?

A I don't recall Dr. Sarah Palmquist telling me anything about that specific type of online pharmacy dispensing medications for Ethan.

Q Did you -- did you ask her what pharmacies they use?

A It might have been in the conversation at

208

the house, but I don't recall the specific name or location of which pharmacy.

Q So is it you did ask her but you don't recall which one? Or you don't know if you asked her?

A I don't recall the specific discussion we had. I know I didn't document a specific pharmacy.

Q Okay. And did you ask her about their use of generics when available?

A I don't -- I mean, some of his medicines are not available generic, and so I don't think we had that discussion.

Q That's why I threw in "when available."

A Yeah, I don't -- I don't think we had that discussion.

Q Okay. And if -- again, this -- if a family routinely used -- filled 90-day scripts rather than 30-day scripts, would your cost survey use 90-day scripts, to be consistent with the family's practice?

A I would -- I would consider that as an update in the future if that was their hundred percent directive on 90 days.

Q Did -- did you ask the Palmquists whether that was the case with them or not?

209

A No. I don't think we discussed that three-month supply.
Q And are there any factors regarding how Ethan's family handles filling prescriptions that would have had any effect on the cost estimate that you put together here?
A So I understand your question as, is there any specifics the family fills prescriptions that had impact on my cost analysis?
Q Yeah. Are there any factors about -- regarding how they fill prescriptions -- whether it's where they go, how frequently they filled them, what have you. Are there any factors regarding how the family fills prescriptions that could have had some influence on your cost analysis?
A I don't think there's any other factors that they informed me of or that you and I have not already discussed.
Q Okay. And did -- let's see. Let's talk briefly about the CBD/THC tincture.
A Uh-huh.
Q Now, this is showing my wild lack of knowledge about modern nonprescriptive pharmacology. But is the 5 milligrams per 1 milliliter -- two questions. One, is the recommended dose here

210

1 milliliter? I could not tell from the report.
A Are we on Page 85?
Q Page 85, yeah.
MR. PARKER: I object to the form of the question. This is prescripted -- this is a prescription.
MS. PALEY: Okay. Sorry about that.
MR. PARKER: Texas, you have to be prescribed. We have medical marijuana by certain certified doctors, et cetera.
MS. PALEY: Understood. I'm in Virginia. We have the same -- my misspeaking.
Q (BY MS. PALEY) So this just generally reflects my wild lack of knowledge about CBD and THC generally.
MR. PARKER: Well, if you want to know, I can tell you about it.
MS. PALEY: I may ask you afterwards.
Q (BY MS. PALEY) The 5 milligrams per 1 milliliter, that's on -- that's a dosage strength, right? That's how much drug you have in 1 milliliter of liquid?
A That's correct.
Q Okay. Is the recommended dosage for Ethan here, is it 1 milliliter?

211

A Again, I'm just going -- making sure we're on the first one, where it says Number 60?
Q Yes.
A Okay. So this first dose is 1 milliliter two times a day.
Q Okay.
A And that's how we get 60 doses per month.
Q And then for the next dose -- well, I should say all three of these doses have the same concentration, correct? 5 milligrams per 1 milliliter?
A That's correct.
Q Okay. And you increase the number of doses per month to reflect Ethan becoming larger, in effect, correct?
A Older, larger and potential for tolerance from the lower dose.
Q Okay. And once he gets up to 180 doses per month, that's about six doses per day; is that correct? Just 180 divided by 30.
A Yes.
Q Is the recommendation still to have CBD/THC tincture twice a day and just have three doses each time?
A Generally speaking, yes.

212

Q And at that dosage level, would that be -- would that be enough to create what the layperson might call kind of a high?
A Typically not. Because this is a CBD product for some of his issues with aggression and his, you know, global term seizure disorder. And so the CBD is helping that. And we're not getting -- I think you mentioned, quote/unquote, high, because it's a tincture concentrate and he's not smoking marijuana, getting high from a hundred percent THC. It's a medical CBD grade.
Q Okay. And I see that it says CBD/THC tincture.
A Sure.
Q And it's actually the THC I was interested in. That's -- that's what is in like marijuana that one would smoke, right?
A Yeah. Yes. And I think the THC is such a small component, but we would have to specifically go to this vendor, Texas Original Compassion and Cultivation, to get the breakdown. But in my experience in multiple states that do medical marijuana, this is not getting high type of tincture because of the CBD/THC combination.
Q Okay. And have you ever prescribed a CBD/

213

THC tincture to a minor?
A No.
Q Okay. And have you ever been asked to by, say, a parent?
A I don't think a parent has ever asked me to prescribe that. In adults, we've had discussions of these types of tinctures or CBD products readily available to help with whatever the diagnosis may be.
Q Would you have any concern with prescribing CBD or THC to a minor in your medical practice?
A I would not have concerns after I went through the specific like state training to do that, because I'm not trained right now to prescribe THC, medical marijuana. But CBD is readily available without a prescription. Given the limited research that I've reviewed, I don't have concerns that this type of product in Ethan's type of diagnoses would have significant detrimental effects.
Q Okay. But you haven't gone through whatever the state training is to actually be able to make such a prescription; is that --
A That's correct.
Q Do you ever prescribe CBD/THC tinctures to your adult patients? And that may be that you don't

214

because you haven't gone through the training. I'm not sure if it's separate for adults and children.
A Yeah, I think I answered that one already. So we can make recommendations for the CBD, because you don't need a prescription. But then I do not prescribe medical marijuana, THC, just to make sure that distinction is clear.
Q Okay. Understood. Okay.
In making your recommendations in this life care plan, did you speak to Dr. Proud, who's the one who originally prescribed this CBD/THC tincture?
A No, ma'am.
Q Okay. Have you spoken to anyone about the potential risks of lifelong use of a product use -- lifelong daily use of a product that contains THC?
MR. PARKER: I object to the form of the question.
A I spoke to the treating neurologist, Dr. Rotenberg. And he did not have any concerns about the daily use and the specific titration schedule on increasing dosage and daily use, is what we discussed. And the specific vendor, because he is apparently licensed to prescribe and recommend this, is -- the discussion I had with him as the treating provider. And that was the extent of our discussion.

215

Q (BY MS. PALEY) Did you specifically discuss the idea of lifetime use of a THC-containing product with Dr. Rotenberg?
A Yes. Dr. Rotenberg was recommending to continue this product for life to decrease breakthrough seizures.
Q And Ethan has what you might call like decreased self-regulation compared to neurotypical individuals; is that correct?
A Can you help me understand what you mean by "decreased self-regulation"?
Q Well, as I understand it, he will undress himself in front of strangers, sometimes engage in acts that might be a little uncomfortable for folks to see. That's one example of what I might call a decreased self-regulation.
A Okay. So I would agree with that, you know, kind of global term where he's unable to regulate his emotions, his physical behavior, psychological behavior, all of those things, yes.
Q Okay. And have you specifically considered the potential long-term health consequences of things like potentially increased appetite with use of a THC product in an individual with decreased self-regulatory capacities?

216

MR. PARKER: Objection as to form.
A So -- so yeah. I mean, we always consider risk/benefits of medicines. In speaking with the treating neurologist who's treating the seizure disorders with the CBD/THC tincture, there didn't seem to be any concern that was brought up or discussed between us.
I think it's also key that it's the combination product, CBD, THC.
Q (BY MS. PALEY) Did you -- did you specifically discuss the idea of potential appetite enhancement with Dr. Rotenberg?
A In my experience, the CBD products does not -- do not enhance appetite, similar to what you've described as getting high or smoking weed. And so I don't think we discussed specifically appetite regarding Ethan.
Q Would you agree that chronic THC use is also associated with things like impaired attention and memory issues?
MR. PARKER: Objection as to form.
A I mean, I would have to review some data on that. There, again, is paucity of data that I'm familiar with, given the controlled nature of this via the DEA classification. So I would just need to

217

review some of that data to then agree or disagree with your question or comment.

Q (BY MS. PALEY) Okay. But you didn't -- you didn't review the data in preparing his life care plan?

A Given prescribed by the treating physician, I didn't feel it was necessary to do that literature search. And I was not asked to do that, so I did not.

Q Let's look at the next item in your medications list. Catapres or clonidine. It's an antihypertensive.

A Yes, ma'am. Clonidine.

Q Oh, sorry. That's right, clonidine.

A C-l-o-n-i-d-i-n-e.

Q Okay.

A Generic. And then brand name is C-a-t-a-p-r-e-s.

Q And you have here a prescription for 15 pills per month; is that correct?

A Yes.

Q Okay. Now, your report says on Page 59 that you believe Ethan would use this, quote, a few times a year.

Help me understand the difference between

218

needing something a few times a year and having a prescription that provides you with a pill every other day.

A Sure. Yeah, let me just review.

Okay. So on Page 59 at the late February '22 or early March of 2022, his mother had reported that they were using it a few times a year at that time that I did the current intake of medications.

After visiting with him in the house and discussing with his mother that it does work to help decrease his hyperactive behavior or aggressive behavior, I thought it was appropriate to increase the frequency of that medication.

Generally, it's listed as a antihypertensive, but that's not what it's used for for Ethan.

Q So even if it's not used as an antihypertensive, it would still have that blood pressure-lowering effect, correct?

A You know, actually the reason why we use it for some of those kids with aggressive behavior, ADHD or social anxiety is because it doesn't lower blood pressure but it lowers the sympathetic storm of adrenalin, and that's going deep, deep into

219

pharmacology on how the medicine works. So typically with patients that have this aggressive behavior, it does that instead of lower their blood pressure.

Q And have there been studies that demonstrate that somehow it doesn't lower their blood pressure?

A That's my kind of clinical experience. I'm not familiar with any studies I could quote you at this time.

Q So based on your discussion with Sarah Palmquist, you understand that Ethan would, under these recommendations, essentially use clonidine for sedation about 15 times a month, not a few times a year?

MR. PARKER: Objection as to form.

A That's right. Not just sedation but decreasing his aggressive behavior, which, you know, when I was there, was hitting me, hitting his 5-year-old sister, hitting Mom, you know, things like that. Throwing toys, throwing books. So that's where the logic is on increasing the frequency, based upon prior use and success, along with mechanisms of pharmacology, current behavior and discussions with the family.

Q (BY MS. PALEY) So has any -- have any of

220

his treating physicians currently prescribed clonidine with the frequency with which you recommend it here?

A I don't think so.

Q Okay. So let's just look quickly at the prices here. You have prices for clonidine of brand and generic from Kroger in Pearland, Walgreens in Pearland and Walmart in Pearland; is that correct? Pages 85 to 86.

A Yeah, I'm sorry. I got some of the pages mish-mashed here. But yes, that's correct what we have here.

Q Okay. And when -- when the person who did this cost survey made that call -- or person or persons who did that cost survey made the calls to the pharmacies --

A Uh-huh.

Q -- do you know what they asked for specifically?

A Yes.

Q What -- how did they go? What did they say?

A My instruction is sort of as it's listed under the first bullet. This is the medicine. This is the dose. This is the number of the pills. What

221

is your price for generic, price for brand name?
Q And that's priced to a cash payor?
A Yes.
Q Okay. And by averaging, let's see -- by averaging the prices together, you get about $29.51 per script; is that right?
A Per month or per script, yes.
Q Okay. Now, if -- just simple math. If you had averaged just the generic prices, it would be something closer to, say -- I mean, I'll just do a quick here -- like $7 or so. You've got a 6, a 12 and a 4 essentially. 99¢, but...
A Roughly. That's quick math. So sure.
Q Okay. So if your methodology were to use average generic pricing, you'd have $7 a month. Using the methodology you used, it's $29 a month; is that right?
A The methodology, yes, is $29.51 a month.
Q Okay.
A And then roughly those numbers you're describing would be the generic-only price average.
Q Okay. Now, let's look at the next one, Lamictal. That's an antiseizure medication, right?
A Yes.
Q And, again, you use the brand and generic

222

from three different stores: Kroger, Walgreens and Walmart in Pearland; is that correct?
A Yes.
Q Okay. And here we see that the brands can be up to $1,918.99 per month; is that right?
A Yes.
Q In fact, the -- of all three of the brands, one is about 19, one is about 1600 and one is about 1700.
A Yes.
Q Okay. And we see -- we see much lower prices with the generics, right? We see about 75, 191 and 164.
A Yes.
Q Is that right?
Okay. So and, in fact, the sort of highest price brand and the lowest price generic, they actually exist at the same store, at Kroger, right?
A That's what is documented here. That's very well possible. Again, from supply chain suppliers of medications from different pharmaceutical companies. Not uncommon in my experience.
Q Okay. And your average price for

223

averaging the brands and generics is 958.06?
A Yes.
Q Did -- did you ever, just out of curiosity, average what the generics might be on their own?
A That's not something I do on my methodology, so I have not done that.
Q Okay. And if I wanted to know what the lifetime -- so we could avoid doing the math here, I just want to map something out. If I wanted to know what the lifetime savings could be from using instead of your average of all the brands and generics, just using the average of the generics, could I take your average minus the generic average and see what that difference is per month to figure out a monthly difference?
A I think if you want to do arithmetic, you can do that. But that's not what I'd recommend in the life care plan methodology or how physicians would prescribe medicines.
Q Well, what do you mean by it's not how physicians would prescribe medicines? Many physicians prescribe generic medicines, don't they?
A So -- not necessarily. When we prescribe medications, it just depends. If we're doing

224

something and I check brand name only or specific medication as prescribed, that denotes more of a brand name for different reasons. And the primary reason is development of the drug and quality control. Brand names have tighter quality control. Generics have more fluff and fillers and less quality control. And we see breakthrough seizures sometimes on generic Keppra versus brand name Keppra or Lamictal.
And so that's a good exercise in math, but that's not necessarily, you know, what I would do at all for the methodology for my life care plan.
Q But you have no idea if the Palmquists are using brands, generics, a mix or what, right?
A That is why the methodology is the average of the two.
Q But is that correct? You have no idea if they're using brands, generics or a mix?
A Well, it's not that I have no idea, because some of the medicine are brand name only. So that answers that question. Regarding something like this, an antiseizure medicine, Lamictal available for brand or generic, I did not ask them specifically. And at times patients don't even know specifically if it's brand name or not, unfortunately.

225

Q Well, Dr. Palmquist is a pretty sophisticated individual, correct? She understands if she's using brand or a generic?

A I'm not going to make a speculative presumption. I'm happy to follow up with her on that and then report back with an update or amendment in order to answer your question in the future. But I can't speculate what she's doing or not doing.

Q Okay. We may -- we may follow up on that. And I won't suggest that you disagreed with her being a sophisticated individual. Just a joke. Just a joke.

A Sure.

Q But if I wanted to do the math and I wanted to understand -- you know, if we can walk through this, this may actually save us a lot of time. If I wanted to do the math and understand what could the price savings be of using generics, understanding that there's variability in generic pricing --

A Yeah.

Q -- could I figure out the generic average, subtract that from your blended average and see what the savings would be per month?

A I mean, I think that's -- that's an

226

exercise in arithmetic. It's not, again, something that I -- I would recommend as author of this life care plan. And doesn't also account for new medicines in the future, which will be brand name only for ten years at higher cost.

And so the other reason and logic for this methodology of averaging is a placeholder for a medicine cost. Because as we go into the future, these costs will go up. So that's kind of the way I would answer that question.

Q Well, these costs going up, that's what Mr. Davenport takes care of, right? By using various inflation rates to predict future drug costs based on government data on inflation?

A That's not what I meant. I'm sorry. Costs going up, if there's a new brand name medicine that controls things better -- let's say seizure, Lamictal -- the brand name, roughly ten years minimum, we can use 1900, 1600. There's no generic equivalent for ten years.

So medication costs are going up. All brand name and new medications are increasing. We can also look at the Humira in here and that expense because it's brand name only. So it's an arithmetic exercise, but it's not necessarily applicable for me

227

to give a total number of lifetime costs of medications because there's going to be replacement of medications, perhaps. And, again, these are placeholders per my methodology based upon the fact at hand when I publish a report.

Q And I'm not actually asking if you would agree is that it's an appropriate thing to do or whether -- I'm not asking whether you would do it. I'm just asking if mathematically the way to understand what the difference is is to take your blended average for brand and generics, subtract the average for the generics and see what the difference is? I'm not asking if you would endorse it. I'm just asking if that's got the math right.

A I think if you want to do that math exercise, you know, you're free to do that. I just wouldn't want to be misleading that that then somehow would change the overall need for this child to be taken care of with medications.

Q And I'm not suggesting that. I'm just asking about the math.

So I take it that you haven't extrapolated out to see what the lifetime savings could be for Lamictal if the family used brands -- sorry, if the family used generics under your cost survey, correct?

228

A It is correct that that is not part of my methodology. And that has not been published in my report because I have not done that for all the reasons we've been discussing.

Q Would you be surprised if the savings for just using generic pricing was about $684,000 in nominal value?

MR. PARKER: Objection as to form.

A I'm not surprised by the cost of medications anymore, because it is something ridiculous in America with one pharmaceutical company I know of having $28 billion in one quarter in sales. So I wouldn't be surprised about that number at all.

Q (BY MS. PALEY) You wouldn't be surprised if the savings could be $684,000 just by using the generic?

MR. PARKER: Objection as to form.

A Again, same answer. Not surprised, given the cost of healthcare medications right now.

Q (BY MS. PALEY) How often, when you prescribe, do you say "brand only"? I forget what the shorthand is for like "no generic replacement," but whatever that is. How often do you say that?

A "Dispense as written" would be the shorthand perhaps.

229

Q Dispense as written.
A Some of my controlled substances prescriptions in the past had a "brand name only" on the DA script, excuse me. Now electronic prescriptions, there's checkboxes to do all that stuff. Again, it just depends. I mean, it's physician recommendation, what's available at the pharmacy, what's on formulary at the hospital. There's so many factors involved. So it just depends on all those factors on what I'm prescribing and what's available.
Q But when you -- that's -- how often do you specifically, on average, write "dispense as written"?
A You know, I'm not sure. I haven't really recorded that.
Q Okay.
A I don't know. I mean, it's definitely happening. It's not more than 80 percent of my prescriptions. But it's definitely occurring in specific instances, especially when patients report better success with certain medication.
Q And your -- oh, sorry. Were you speaking?
A I was just letting the fire truck noise finish. But all I was saying is medications, and

230

then the fire truck noise.
Q Understood. When -- when doing your cost survey for medications, you specifically include like national-level retailers who are sort of available for filling scripts around the country, right? You use local -- local outlets, but you're using national-level retailers, right?
A That's correct, as documented and discussed with the specific Kroger, Walgreens, Walmart, et cetera.
Q Okay. Have you ever looked at an online retailer like Amazon pharmacy?
A I have never used Amazon pharmacy. I don't think it's been around very long, and so I've never specifically looked at that retailer.
Q Okay. Let's look at Amazon pharmacy for Lamictal.
A Sure.
(Exhibit Number 12 was marked.)
Q (BY MS. PALEY) This is Exhibit 12. I apologize, it's getting really hot in here again.
A No apology, since we're at my office, but not specifically in my office.
Q Okay. So looking at this, do you see just -- I printed this out from my computer screen.

231

Do you see at the top it says, Search Amazon pharmacy?
A Yes, I see that.
Q And then a little ways -- about a third of the way down the page, it says, Lamotrigine? Is that how you say it?
A Yes.
Q And then it says, Tablets, generic for Lamictal.
Is that the generic of what you have included in your life care plan, Lamotrigine generic for Lamictal?
A On the surface, that's what these letters and words are on this paper. But I can't verify, you know, Amazon pharmacy. It appears to be reliable.
Q Okay.
A But I've never used it before.
Q Do you -- do you have any reason to suspect that Amazon pharmacy would send out counterfeit drugs or anything like that?
A My concern for bias is that, Number 1, it says, Prime membership. So apparently you have to be a Prime member to get this $76. Number 2, that's about roughly a dollar and a half more expensive than the Kroger Pearland generic.

232

And Number 3, my biggest concern is that it's understood by physicians that certain large -- I use Walmart as an example; perhaps Amazon is doing this -- is going to discount medicines to get you in the store on the website to buy other things.
Q Well, Doctor, you include Walmart as one of your options for Lamictal, right? I mean, you don't have anything against using large retailers?
A So -- so to be transparent, that's why the Walmart Clonidine is $4 on generic. That's a $4, get you in the door. They're losing money on that medicine so you can then buy something else from Walmart.
Now, again, with transparency, methodology, reproducibility, it's important at times to include those low costs so we get a good average of what's available in the market.
Q Okay. And you don't -- you don't include this low cost from Amazon in your cost survey. Just a factual question there.
A That is a fact.
Q Okay.
A We did not include Amazon. That's not something that I've ever done, and I would not move forward to routinely do that in the near future.

233

Q And you've mentioned, it sounded like, it was more expensive. Let's look at what I printed out here. This is a hundred milligrams a day. That's the dose Ethan is taking, right?
A Yeah.
Q And it says three tablets per day, right? That's the highlighted -- it's a little hard to see here, but it's three tablets a day is the button that was selected. Do you see that?
A Yeah, I see that.
Q Okay. And then the supply is actually a 90-day supply. Do you see that? That's the button that's selected?
A I do see that.
Q Okay. And so that's a three-month supply, right?
A That would -- yeah, that would denote here under three months.
Q Yeah. So if it's about $76 for -- for three months, that's about $25 a month, right? A little more?
A Roughly.
Q Roughly. Okay. And so that $25 a month compared to the lowest generic price you have for Lamictal -- what's the lowest generic price you have

234

for Lamictal?
A It looks like it's the Kroger at 74.99 --
Q Okay.
A -- a month.
Q Sorry. I did not mean to cut you off.
So the Amazon price is about a third of the lowest generic price that you have?
A That's what this Exhibit 12 is showing.
Q Okay.
A I --
Q And so if you -- I'm not saying you have to just take the Amazon price. But if you included the Amazon price in your average, it would bring down the average, right?
A It would, if the medicine was comparable. But I don't know where they're sourcing this drug from.
Q Do you have any specific reason to believe it's not comparable?
A I'm not familiar with Amazon pharmacy. I don't think it's been around a long time. I'm not sure how to submit a prescription there. So I think there are some concerns.
And then, again, different medications from different manufacturers have different types of

235

densities and quality control. And so I'm not certain if it is a hundred percent comparable to the brand name, number one. And in my experience, a bigger Walgreens, Kroger pharmacy is a little bit more consistent with their supply chain.
Q Do you have -- did you do any work to understand the sourcing of the generic Lamictal from Walmart or Walgreens or Kroger when putting together this cost survey?
A Not specifically for this. But in my career I have looked at different US pharmaceutical companies making drugs in the States for some big commercial retailers like Kroger and Walgreens.
Q And have you specifically determined that for Lamictal, Kroger and Walgreens and Walmart have adequate sourcing to meet your requirements to be comfortable with the generics?
A I did not do that for this report.
Q Okay. Did you do that for any of the drugs in this report?
A I did not.
Q Okay.
A The ones that have both options available.
Q Okay.
A That wasn't applicable for like Humira.

236

Q Thank you. And let's -- it's always -- it's good to have more data points, right? Like one of the reasons why you like the U -- the Context 4 Healthcare is that they have a lot of data points; they have billions of data points, right?
A I think data points can be helpful with a strict methodology that's reproducible. And at times erroneous data points, outliers -- and this is defined as an outlier, this Amazon price being so much lower than the rest of it -- can be confusing.
Q How do you know if it's an outlier if your sample only had three pharmacies?
A Well, I think that that's pretty clear; that you're mentioning a third of the cost. And so that would be a far outlier compared to the three pharmacies that we -- that we sourced for comparison.
Q And you just looked at those three, right? You didn't look anywhere else?
A Correct.
Q Okay. Let's look at Exhibit 13.
(Exhibit Number 13 was marked.)
Q (BY MS. PALEY) Now, I do apologize for the print quality here, but this is printed from one of my -- from my browser. Exhibit 13, do you see that this is from a website, GoodRx? Do you have any

237

familiarity with GoodRx?
A I do.
Q Okay. Have you ever filled a script through GoodRx?
A Personally, I don't take any prescription medicines, so no, I've never filled a prescription with GoodRx.
Q Are you comfortable if your patients want to fill a prescription with GoodRx? Do you have any concerns about that?
A Well, I don't think they fill it with GoodRx. I think they take a little discount card and show up at the pharmacy.
Q Okay. So GoodRx actually lets you go to your local pharmacy with a discount card and get prescription medications for lower prices than you might be able to get them without the discount card; is that right?
A Compared to insurance, co-pays or cash rate options. In general, I think that -- that is a good understanding of how that GoodRx card works.
Q Okay. Did you ever warned any patients away from, you know, getting a GoodRx card?
A No, I have not.
Q Okay. Do you have any concerns with

238

patients using GoodRx cards?
A I don't have any concerns with them using a GoodRx card. It's just not something that we are employing and I'm employing into my methodology to price out the cash or self-pay option for prescription medications in this report.
Q Okay. And if someone goes and fills a prescription with a GoodRx card, they are -- they're a cash payor, because they're not using their insurance at that point, right?
A I'm not sure. I think it's potentially variable. I'm not sure since I personally have never done it, like I mentioned.
Q Okay. So let's look quickly here. Do you see it says, First, match your prescription, and I typed in --
THE REPORTER: First what?
Q (BY MS. PALEY) First, comma, match your prescription.
A Match, M-a-t-c-h.
Q Correct.
A Correct.
Q And do you see it says, 100 milligrams Lamotrigine, 90 tablets?
A Yes.

239

Q Okay. And that 90 tablets, that would be what you recommend for Ethan on a monthly basis, right?
A Yeah.
Q Taking it three times a day?
A Correct.
Q Okay. And so -- and the -- it says, Next, pick a pharmacy to get a coupon.
Do you see I typed in here, Pearland, Texas, zip 77581?
A Yes. I see that.
Q Okay. So this is providing pharmacy information for pharmacies in Pearland, Texas.
THE DEPONENT: The button -- the button, I'm sorry. Green button.
Q (BY MS. PALEY) Okay. And so, Doctor, do you see -- what's the price for the -- I don't know how people say it, HEB or HEB grocery store?
A Yeah. I see HEB $12.46, among all the other vendors as well.
Q Uh-huh. And what's the price at Costco?
A Costco is $10.97.
Q And you can fill scripts at Costco without being a Costco member, right?
A I don't know. I don't do that.

240

MR. PARKER: Objection to form.
MS. PALEY: He doesn't have to know. It's okay. You can.
Q (BY MS. PALEY) And then Randall's. Randall's is a pharmacy or supermarket? Do you know?
A I believe it's both.
Q Okay. And what's the price at Randall's?
A $9.18.
Q Okay. So just here -- and I understand that there are other prices as well, prices up to 111.09 and as low as 9.18. Just -- you didn't -- you didn't look at this pricing available through GoodRx as part of your cost survey, right?
A We never do, in a life care plan following the specific methodology to -- to then try to price this out as a discounted rate. And there's numerous reasons why. And I think I've pretty much mentioned the majority of them at this time.
Q And PLCP, they're the ones who put together the methodology?
A No. The methodology is formulated from initially the case management and life care planning handbook, along with the Guide to Physician Life Care Planning book that we discussed. And then I have -- I have the ability to deviate, but I always want to

241

be able to explain the methodology, have it reproducible, be able to get the exact same cost priced out and have it transparent. And those reasons, along with all the other specific reasons we talked about on specific medications, I do not use GoodRx for this cost analysis.

Q Okay. But if -- if you were to use these prices available at local pharmacies in Pearland for lamotrigine, then do you agree that the average price in your life care plan would go down?

A Well, I'm not going to use them in my life care plan. If a patient or the mother of a minor chooses to then acquire medications through GoodRx, that would be their choice. And that, yes, clearly would be a lower cost compared to the options that we have sourced in the life care plan consistent with our methodology.

Q And when putting together this life care plan, you don't say to the family like, Now you can only go to the pharmacies that I included in my methodology. They have complete freedom to go and search for options such as these half-dozen or more options available in Pearland through the GoodRx program?

A Both of your statements or questions are

242

correct.

MS. PALEY: Okay. All right. Should we take just a little stretch break?

MR. PARKER: I think we would like that.

MS. PALEY: Okay.

THE VIDEOGRAPHER: The time is 3:09. We're off the record.

(Recess from 3:09 p.m. to 3:25 p.m.)

THE VIDEOGRAPHER: The time is 3:25. We are back on the record.

Q (BY MS. PALEY) All right. Welcome back, Doctor.

Just to maybe save us a little time here, I was asking you about lamotrigine -- I might have butchered that.

A Lamotrigine.

Q Lamotrigine.

A I understand exactly what you mean, yes.

Q Lamotrigine. And availability through various retailers such as Amazon or using GoodRx coupon cards to fill it at local pharmacies in Pearland. If I were to ask you the same questions about any of the other medications Ethan asks [sic], would the answers be effectively the same? You haven't considered those sources, and you don't

243

believe that those sources are appropriate to consider under your methodology?

A Yes. Thank you for summarizing.

Q Okay.

MR. PARKER: That was a wonderful question and answer.

MS. PALEY: Exactly what Charlie wants. Charlie wants to get back to his ranch. And it is Friday afternoon, which I understand is hard.

Q (BY MS. PALEY) Quick few questions about Humira and then we can move on from the drugs.

A Yes.

Q Humira is under your plan -- well, not under your plan. Humira is not available in generic form right now, right?

A It's my understanding.

Q And Humira is right now a fairly expensive drug and actually the single largest cost driver of the pharmacy part of your life care plan, right?

A Yes.

Q Around $6.4 million in your nominal values, right?

A Yes.

Q Okay. Do you have any sense of when a Humira generic or -- pardon me -- biosimilar may be

244

available in the market?

A I think that might be a question for Dr. Krigsman, the treating gastroenterologist. My sense is minimum of ten years before that's potentially allowed for -- the FDA would allow a generic option solution to be produced or sold.

Q And so at the point at which a generic option or solution or biosimilar option or solution is produced or sold, then would it be appropriate to sort of update the understanding of costs based on, using your methodology, a blend of generic and brand costs?

A I think that would be reasonable at that time.

Q Okay. Let's look at Exhibit -- I think 15? Do you have 14 --

A 13 I think is GoodRx.

Q 14. Okay. Then Exhibit 14.

(Exhibit Number 14 was marked.)

MS. PALEY: Sorry. That really did not fly.

Q (BY MS. PALEY) All right. Do you see Exhibit 14 is an FDA news release?

A I do.

Q And do you see it says, FDA approves

245

Cyltezo, the first interchangeable biosimilar to Humira?
A Yes.
Q And do you see that the date on this is October 18th, 2021?
A Yes.
Q All right. Do you see at the bottom of this page, in the last sentence it says, Cyltezo, what it's indicated for, and that includes, at the end of the sentence, Pediatric patients 6 years of age or older with Crohn's disease?
A Yes.
Q So Cyltezo, according to this FDA news release, would be approved to treat Ethan's Crohn's disease as an interchangeable biosimilar to Humira; is that correct?
A I mean, that's what it's stating on this news release with -- where is the source? Is it --
Q At the end, you can see Inquiries, and it's to an FDA employee and consumer line is 888-InfoFDA?
A So FDA.gov.
Q Yes. FDA.gov is the source.
Can you look on Page 2 of this document, Doctor?

246

A Uh-huh.
Q And see on the fourth line down, do I read correctly when I say, Patients can expect the same safety and effectiveness from the biosimilar as they can from the reference product?
A That's what it states.
Q Okay. So do you have any specific reason for concern if Ethan were to use Cytelzo as a biosimilar to Humira?
A My -- my two concerns would be, number one, there may be or must be a reason the treating gastroenterologist hasn't switched him. My second concern is that it states in the third paragraph that it's to be injected under the guidance of a physician. So I would need to know exactly what frequency -- once a month, once every two weeks -- and does that actually mean in an office under the guidance of a physician or not.
Q Well, Doctor, I'll represent that the FDA has approved it. It's not -- it's not available at pharmacies quite yet, but -- so that's why -- just to clarify, that's why, you know, there's no way for Ethan to take this right now. But it's been approved by the FDA.
A Okay.

247

Q So do you -- if -- if Ethan's treating gastroenterologist said it was appropriate for him to take Cytelzo as a biosimilar that the FDA says, From which patients can expect the same safety and effectiveness as the reference product, Humira, would you have any concerns with that?
A If the treating gastroenterologist recommended or prescribed it, then -- then no, I would not have any concerns. I still would just want to review administration route and clarification under -- quote, Under the guidance of a physician, end quote.
Q And what -- why is that important to you?
A Well, because at times, certain medicines have to be administered in an office, monitored; certain subcutaneous injections or IV administration. And so if it is that guidance of physician in office being monitored with vital signs or whatever timeframe, then that maybe would create a logistic concern where it's not going to be prescribed because of that and having to get Ethan to that office.
So, you know, those are just logistic concerns that typically I would defer to the treating gastroenterologist to discuss and/or determine if he's going to switch the medicine.

248

Q And you understand that when generics or biosimilars come on the market that, on average, you know, prices come down, correct?
A I mean, I don't know if this is a generic, because it sounds like it has a brand name to me and it's a different company. So I don't know if this is actually a generic. So I'm not sure if I can answer that question right now.
Q I actually said generic or biosimilar.
But let me point you to the second paragraph on Page 2, last sentence. Do you see the FDA says, Biosimilar and interchangeable biosimilar products may cost less than the brand name medicine?
Did I read that correctly?
A I'm sorry, where are you again?
Q Second page, second paragraph.
A Okay.
Q Last sentence.
A Biosimilar and interchangeable, biosimilar products may cost less than the brand name medicine.
Q Do you have any reason to, you know, understand that in this case, for whatever reason, Cyltezo certainly would not cost less than Humira? Any data that would suggest that?
A No data, just what you told me. If it's

249

not available right now, but it got approved October 15th, 2021, I would want to know why it's not available. And then for the discussion, what would be the cost if it was available.

Q When preparing the -- the life care plan cost analysis for Humira, did the individuals who called the pharmacies have any discussion with the pharmacies regarding manufacturer coupon programs or rebate cards that are available to consumers to reduce their out-of-pocket costs for expensive drugs like Humira?

A We typically do not employ that in the methodology, similar to the GoodRx. So we get an understanding of the full cost of the medicine.

Q Okay. So if there -- if there are coupon cards that will make Humira as low as $5 a month out of pocket for a patient, that's not included in your methodology. You used the 7600 or so dollar list price from the pharmacy?

A That's correct.

Q Okay. Let's talk about rehabilitation services. We can look back at your report. Now, Page 213 I believe has a summary of the recommended rehabilitation services included in your report.

Do you see that?

250

A Yes. Thank you.

Q Okay. And I will say your report format is nicely organized, and it made it easy to go through. So thank you for that.

All right. Page 213, rehabilitation services costs. Let's look at Item 8. Item 8 is listed as occupational therapy home health.

A Uh-huh.

Q Now, home health is also listed somewhere else here. I take it when it says, Occupational therapy home health, that means it's an OT person coming to the Palmquists' home to provide occupational therapy services. Is that a correct understanding?

A Yes.

Q Okay. And looking over across the page on Item 8, the occupational therapy, you have that beginning at age 7, right?

A Uh-huh.

Q The quantity is one unit, right?

A Yes.

Q And that's one unit per day, correct?

A Yes.

Q Okay. For 11 years?

A Correct.

251

Q Okay. Now, that one unit per day, that's 365 days a year or 366 days a year if there's a leap year?

A Correct.

Q Okay. So that includes every weekend?

A Yes.

Q It includes every holiday?

A Yes.

Q It includes Christmas Day even?

A For the purpose of this report, yes.

Q Now, do you have any support from any practice guidelines or any medical literature demonstrating that patients with autism or with Ethan's presentation derive effective -- strike that.

Do you have any support from any practice guidelines or medical literature demonstrating the effectiveness of daily, 365 days per year, for years on end, occupational therapy in children with autism?

A The sort of thought process here is the current kind of situation at home and optimization of occupational therapy at home, along with the discussion I had with Dr. Settles on more intensive daily therapy, even on the weekends, to avoid a change in his schedule.

The specific questions on literature,

252

guidelines, I do not have those guidelines demonstrating recommending daily occupational therapy.

Q And do you have any support from Ethan's providers -- not from Dr. Settles, who is an expert in this case, but from Ethan's providers --

A Uh-huh.

Q -- that would support the claim that Ethan needs an hour of occupational therapy every day of the year including Thanksgiving, Christmas, every weekend?

A I did not discuss those with the two treating providers that I did contact, but we can always send them my report and then ask them if they support my recommendation.

Q Okay. And have you looked in the medical records to determine how often Ethan was receiving occupational therapy or how often -- or how often -- the frequency with which his providers suggested he should receive occupational therapy?

A I believe I had reviewed that. I'm not sure exactly where that is along with his mom, Dr. Sarah, telling us his frequency.

Q And we can save some time here if I either go through the report or I could ask you here. Would

253

you be surprised to know that every reference in your report to occupational therapy is for occupational therapy two times a week?

A What do you mean reference in my report?

Q Sure. Let's look at Page 13 of your report. And I'll just let you know, here is my process. I looked for every time "occupational therapy" or "OT" came up to see what has he received or what have his providers suggested he receive.

A Got it.

Q So Page 13, the March 1, 2018, entry that starts with, Ethan underwent a speech therapy revaluation. There's a second undated bullet under that that begins, Records indicate Ethan had a follow-up consultation with Dr. Megson?

A Yes. The undated bullet underneath the bolded March 1, 2018, is trying to tell me, the reader, it's actually on the same date as March 1st, 2018 above.

Q That's what I figured it probably was.

And do you see in that paragraph, it says -- it starts to list, Dr. Megson noted Ethan was receiving, and it includes a list of therapies and occupational therapy, OT, two times per week?

A Yeah. I see occupational therapy, OT two

254

times per week, comma, and behavior therapy three days per week based upon his telephone follow up March 1st, 2018.

Q Okay. Now, let's look at Page 26 of your report, December 30th, 2019.

A Okay.

Q Ethan underwent an occupational therapy revaluation at River Kids Pediatric Home Health.

Do you see that?

A Yes.

Q And do you see the third line down it says, He was provided a treatment plan which included therapy two times per week for six months? Do you see that?

A Yes.

Q Okay. That's another reference to OT -- a recommendation of receiving it twice a month, right -- or sorry, or twice a week, right?

A Yeah. Almost two and a half years ago, that was a recommendation.

Q Okay. Let's look at Page 28, January 27th, 2020. And do you see about five lines down, Dr. Dillon stated Ethan remained on occupational therapy and physical therapy two times a week and remained on ABA?

255

A Yes.

Q Okay. Can you point me to anything else in these records where Ethan's providers have recommended OT anything more than twice a week?

A I can't point to any of that prescription for care for occupational therapy more than two times a week. And I obviously had a different methodology as a life care planner for my recommendations than his treating physicians.

Q Okay. Let's see. And for the occupational therapists, the cost survey includes providers who are -- several providers who are more than 30 miles away from the Palmquists' home. Did -- in -- in calling the OT providers who are included in the survey, did the individuals who made those calls indicate where the therapy would need to be provided?

A I'm not sure. I'd have to reach out to them to ask them, my staff, if they specifically address location in Pearland.

Q And the -- I'll just note, the providers who are farther away from the Palmquists' home have much higher costs. So I wanted to understand whether any part of those higher costs came from the fact that this would require significant driving by the therapist.

256

A That's a good question. I'm not sure. In my experience, there's a listed -- like the first one, the specific address is probably their corporate headquarters, but that doesn't necessarily mean that an occupational therapist is personal home, headquarters, then to the client's home.

In my experience, the home health therapists are kind of around all of their clients or patients, and then they actually go home. That's here in Denver. So we would have to follow up with these companies and/or ask them that specific question.

Q And when calling these providers on the phone, was there the specific request as to whether they could provide OT 365 days of the year?

A I don't think that was requested either.

Q Okay. Let's talk about speech therapy.

A Uh-huh.

Q Speech therapy, the cost survey numbers on Page 93 and Page 213 has your chart as to recommended frequency.

A Yes.

Q So you're recommending, is it 60-minute speech therapy sessions?

A Yes.

257

Q And this is also provided in the home?
A Yes.
Q Okay. And this is also another therapy that you're recommending 365 days of the year or 366 in the leap year?
A Yes.
Q Okay. And do you have any practice guidelines or medical literature demonstrating that that is recommended -- that frequency is recommended for children with Ethan's presentation?
A I do not.
Q And do you have any recommendations from Ethan's providers that he receive daily speech therapy?
A I do not.
Q Okay. And similarly for speech therapy, was there any effort to find providers near the Palmquists' home specifically?
A Just kind of what we identified here, which are similar -- similar companies like home care options in Pearland, Texas, et cetera.
Q And so in terms of the home care providers, does the same sort of methodology apply to how the occupational therapy provider costs were sourced as speech therapy, home health, et cetera?

258

A Same methodology --
Q Okay.
A -- for sourcing those costs.
Q Okay. You're saving yourself a lot of questions by -- by explaining that. Thank you.
Okay. Let's speak briefly about the -- the special school needs -- actually, behavioral therapy --
A Uh-huh.
Q -- Number 4. This is another therapy where you have Ethan receiving daily therapy one hour a day, 365 days of the year?
A That's correct.
Q Okay. So we have three therapies that Ethan is supposed to -- under your life care plan, receive, every day, correct?
A That's correct. I don't think he will be able to get any of this therapy at ABA or the special needs school. So that's where the kind of at-home therapy comes in play.
Q Would the behavioral therapy also be provided in the home?
A I think there's options on that. If there would be a specific therapist willing to come home, that perhaps would be an option -- come to their home or other locations where family members, transportation allowance, home healthcare aides, parents would drive him to that behavioral therapy.

259

Q And you say that you don't think he'll be able to get any of this therapy -- the behavioral therapy, the speech therapy or the occupational therapy -- in the special needs school. Did I understand that correctly?
A Yes. Typically it's nowhere near the amount of therapy that I'm recommending he receive. It may be one hour a week perhaps. That would be something that we would just need to review with like Avondale House specifically.
Q And what is the -- that's actually my question. What is your basis for saying that their curriculum would not include a sufficient amount of behavioral, occupational and speech therapy if you haven't specifically spoken with Avondale House about their curriculum?
A Speaking with Dr. Sarah/Mom about their curriculum and then reviewing their website on kind of this adolescent special needs school age and then what they offer and then moving into the adult program as well.
Q Okay. The website actually doesn't say

260

one way or another what's included within the curriculum, right? They don't include like, Here's what a daily life -- daily life in an Avondale student would be, right?
A Well, I think there's some information on what it's like there. But, again, in my experience, I don't see the specific rehabilitative therapists going to that type of school. That's something in addition outside of the home, et cetera.
Q You don't normally act as a coordinating care provider for children with autism, right?
A That's correct.
Q Okay. And you have no specific information to say whether Avondale does or does not include a sufficient amount of those therapies?
A Just what we discussed on the website review, I did not see that they are offering those specific therapies directly.
Q But the website didn't say what they were or were not offering, right?
A You know, I don't recall were or were not offering. I just don't remember seeing that it was there. So that's something we can follow up on.
Q Okay. All right. We can -- just a second.

261

All right. Let's mark as Exhibit 15. This is Avondale House, Our Services.

(Exhibit Number 15 was marked.)

Q (BY MS. PALEY) Now, there's the Avondale House residential program, the program for young adults and then there's the school, right?

A Yes, that's my understanding.

Q I'll represent this is the printout from the school.

A 374.

Q And Exhibit 15 is right in front of you now. Are you trying to get those pages in order?

A Yeah. I'm sorry.

Q Okay. All right. Exhibit 15. Do you see this is Avondale House, the School at Avondale House, top center of the page?

A Yep.

Q Okay. And it says Our Services. Okay.

A Okay.

Q Do you see that?

A Yep.

Q Flip over to the second page. You see information about like number of students, student/teacher ratio, approved by the Texas Education Agency. Second paragraph. It says, With

262

certified teachers, licensed specialists, well-trained paraprofessionals, a low teacher-to-student ratio and state-of-the-art classroom, our educational program is tailored to meet the specific individual needs of each student, correct?

A Yes.

Q Okay. And then it goes on to say, the second sentence in the next paragraph, Each student receives education and training according to the individual -- to the child's individualized education and behavior improvement plans.

Did I read that correctly?

A Yes.

Q Okay. Does this say one way or another whether the students do or don't receive behavioral, occupational and speech therapies?

A My interpretation of this would be that there are not OTs, PTs or behavioral therapists working with or treating in the middle of this Avondale House school or school day program.

Q Okay. But you didn't call them to find out?

A No, I did not. I delegated that to my staff for the cost analysis piece of it.

263

Q And did you ask your staff to specifically determine what therapies or services were provided by Avondale House?

A No, because we used other things we were describing as specific vendors or the UCR data for the Section 7.45, Rehab Services.

Q Okay. How long is the school day at Avondale?

A I'm not sure.

Q Okay.

A It could be probably anywhere from eight to 12 hours.

Q Okay. So eight to 12 hours. And then you recommend three hours a day of therapy for Ethan.

So is that between 11 to 15 hours a day of structured school and therapy?

A That sounds about right.

Q Okay. And then in addition to those daily therapies, you also include, with some regularity, additional things like behavioral psychologist, family counseling and other activities that would require Ethan to be involved in a program for a few hours a week, right? That was a bad question.

In addition to the 11 to 15 hours a day of scheduled school and therapies that you have here,

264

are there other treatment recommendations in your life care plan that Ethan would undertake at this time, before age 18?

MR. PARKER: Objection to form.

A So -- yeah. I think, you know, having the doctors' visits, you take the child to the visit and you bring them back to school. Family counseling could be as a family. Typically meaning the parents and the child, but typically it's more for the parents and/or grandmother or -- so -- so yes, at times that there would be, again, hours, perhaps out of the, you know, special needs school at Avondale House.

Q (BY MS. PALEY) Okay. There would also be the weekly developmental specialist, right?

A Yeah. I think that would be a consideration to -- for him and his family to see.

Q And the weekly behavioral psychologist?

A Yes.

Q Okay. What transportation options does Avondale school provide?

A I don't think that they can pick him up from their house. Discussing with the family, they would drive, either grandmother or the two parents, would drive him to that -- to Avondale House.

265

Q Okay. So you did specifically discuss transportation with the Palmquists?
A We did touch on that when I was there at the home visit.
Q Okay. So let's move to the -- we were looking at Page 213 that has the rehabilitation services. The post acute neuro day program, Item 12.
A Yes.
Q Is this essentially a bridge program between ending school and entering a residential home?
A Yes. Speaking with the family on some of the preferences, you know, kind of the 18 to 21 transition age. And so that's where we call it the post acute day neuro program where then Ethan would come home and sleep at the house, but he would be then back in school the next day.
Q Okay. And do you have any sense of the transportation options that this program would provide?
A I think it was similar to what we were discussing with the family; that they would be responsible to take him there.
Q Okay. I know you've got within your report about $500 a month, I believe, for

266

transportation costs. What is that meant to cover?
A I think Sarah and Grant did mention things about their work schedule. At times, they may not be able to balance their workflow and be able to do all the care that they're already doing with Ethan. And that's why grandmother or grandparents I was told drive him at times.
And so if we have a transportation allowance, that would allow for a consistent driver to some of these daily routines, like the special needs school at Avondale House, and take the burden away from the parents and try to decrease their amount of caregiver burnout.
Q Okay. And I misspoke. It's actually $500 a week in transportation costs.
And if we want to look, it's Page 246 of your report. But there's --
A I recall, yes.
Q Okay. Your report includes no vendor survey or any -- frankly, any substantiation for $500 a week in transportation costs, right?
A I'm happy to discuss it now if you'd like.
Q Yeah. I'm just wondering, what's the support for the $500 per week?
A Sure.

267

Q Because I don't see anything in the report.
A Yeah. You know, I -- so basically if we were to use a professional driver or like -- I hate to say the ride-sharing, but that type of option, $50 one day -- one way, excuse me, return home, another $50, that's a hundred dollars a day. That's five days a week. That's $500 a week. And that would be able to get Ethan to Avondale House and not rely upon the parents to decrease their personal revenue.
And then I think that also would contribute to the parents having caregiver burnout doing that.
Q Okay. But in your report, there's no substantiation for the hundred dollars a day, right? It's just kind of a number you've picked because it sounded right?
A It's a number I picked based on conservative estimate on how much it costs to get a professional driver, an Uber, a Lyft, a ride share, things like that.
Q But none of that is documented in your report, right?
A No. This is -- isn't typically documented in my report. I reserve usually this discussion for

268

this type of environment in deposition.
Q Since we're on the page, let's just run through the other two quickly. Home modification, $50,000. Again, nowhere documented in your report is what that $50,000 would be spent on. There's no cost survey, right?
A Not --
Q Let me strike that, and I can ask again.
Does your report include any sort of a cost survey or other data to support the $50,000 number specifically?
A Excuse me. It's an estimate based upon things outlined in like the history of present illness, what the damage he's caused to the house specifically. So those would be safety modifications and repairs. And this was, in my mind, very, very conservative, given the experience I have and the type of repairs and costs right now this year.
And so that is the logic and explanation for home modifications. The bars on the window, repairing the drywall and the kitchen damage, things like that, the fence damage, the yard damage, safety concerns and/or repairing.
Q Did you talk to any contractors? Do you provide any substantiation for the $50,000

269

specifically in the report?
A It's just an estimate based upon my experience for those safety and -- concerns and damages already caused by Ethan.
Q Okay. And that's your experience as a layperson who might have done work on his house?
A I have a little bit more experience than just a layperson. But that's, again, a conservative estimate in my mind, walking through their entire home and listening to the family describe what -- what needs they have for safety and what damage he has already caused.
Q Okay. And just very briefly, what is that -- that experience beyond a layperson experience?
A Oh. I -- my wife and I have three LLCs for development, entitlement, zoning, and she's a professional landscape architect. So we have lots of projects that we work on together.
Q But you're not talking about yard beautification here. You're talking about like bars on windows?
A So one thing for him is a bar on a window. I'm not talking about landscape for yard beautification. We're talking about fixing some

270

exposed areas of mud and dirt that he was getting in. There's exposed areas of the fence he can crawl under and then go to the neighbor's pool. And that would not be good.
And there's other damage that he's caused in the house all over the place, from drywall to baseboards to kitchen to cabinets to drawers to bathrooms. So that, again, is an overall estimate that is just a -- I think a conservative estimate of what it would cost until the age of 21 when he's out of the house, for them to maintain safety for Ethan and the two younger daughters.
Q Okay. But there's no -- there are no details in your report as to how you came up with that estimate; is that correct?
A That's correct.
Q Okay. Essential services, a thousand dollars a month. What do you mean by essential services?
A Essential services could be a maid service, a lawn service, help with laundry. So things like that. It could be a chef. It could be helping with cooking, cleaning up. Their house, unfortunately, was in poor repair. There was lots of clothes exposed with soil in the laundry room with

271

about five or six baskets of dirty clothes in succession.
And so essential services would be all of those different things in the home environment for home maintenance, home cleaning, to decrease that burden on the parents so they can focus on the two younger daughters and Ethan and their jobs.
Q Now, everyone -- you and I and Mr. Parker here -- we all have to either keep our homes clean or pay someone to keep them clean. But that has nothing to do with having a child with autism, right? We all have to cook, right?
A Well, I think it does have to do with child's specific -- excuse me, Ethan's specific diagnoses or a child with autism, because they were very clearly -- and my home -- is unable to maintain a clean environment, which does have concerns, because both parents are working. She has a lot of things on her plate as a physician. And it was not -- it was not clean with the amount of dirty laundry. And she expressed concerns about that and how essential services would be extremely helpful for her and her family.
Q But I mean, you have no evidence that -- strike that.

272

You also suggest that Ethan should have -- I think it's 28 hours a day of home healthcare, right?
A Not exactly.
Q Well, you have a 16-hour a day recommendation every day of the year and a 12-hour recommendation every day of the year, right?
A So this is two at once. And so it's recommended by me and others that he have two adults supervising him. So if we were considering, again, kind of the amount of time in school and transportation and then having the hours for the home healthcare aides to drive to his house and then supervising him 16 and 8 would be 24, the lower number. 12, I think then I have supplemented with a licensed vocational nurse for medication administration. That would be the only way for the parents to functionally take care of the two younger daughters and be able to leave the house with Ethan at the house, outside of eight hours in school, with two adults, home healthcare aides, watching him, which includes time at night.
Q Okay. So let me make sure I got that.
A Okay.
Q Do you -- do your estimates include the

273

home healthcare aides going to school with Ethan or being at the Palmquists' home when Ethan is at school?

A So let me just review Page 250, nursing attendant care, make sure we're exactly on the same page discussing this.

Item 2 is home health aide, 16 hours, and 3 is the home health aide -- 12 hours --

THE REPORTER: I'm sorry?

THE DEPONENT: Which part? I'm sorry.

THE REPORTER: Item 2 is home health aide, 13 hours?

A Correction, Item 2, home health aide, 16 hours; Item 3, home health aide, 12 hours; Item 4, LVN care, four hours.

So the thought process and the methodology here is two adults, which would be home health aide 16 and then home health aide 12, it's plus LVN 4. That gives two adults supervising him at all times when he's home and not at school, and that accounts for the different changes in the schedule, et cetera, utilizing what we already talked about, an average of eight hours a day in school.

LVN care is so that the licensed vocational nurse can actually administer the

274

medications for Ethan, because a home health aide would not do that. So that, in my mind, covers his safety. It allows the parents to take care of the daughters, prevent their caregiver burnout. And that then is the eight hours roughly in school for a total of a 24-hour period.

Q (BY MS. PALEY) So your recommendation is essentially, except for an estimated eight hours a day at school, Ethan at all times has two non-parental adults monitoring him, watching him, including two while he's sleeping at night?

A We definitely have some history of outbursts at night and things and aggression at night. And then, again, we have to protect the younger daughters.

In addition, I think it's important that the general methodology and sort of the plan for home healthcare aides cannot always include a spouse or parents because they're not always available. There's a high rate of caregiver burnout. And so as we're predicting costs for these life care plans, family members, spouses, parents are removed from that supervision to then optimize this 16 hours a day home supervision. And then that's where then the cost analysis comes from.

275

Q Okay. And so under this plan, the Palmquists could both leave the home, you know, at any time with their -- say their other daughters, and Ethan could remain home with the home health aides; is that correct?

A Until the age of --

Q Until the age of 18 or I think 21.

A -- 21. So we very well could extend that forever to the age of 70 and then remove the additional cost of the day -- not day program but the full adult home.

So the preference was, with the family, to have this now until the age of 21. But then realistically they were telling me they don't think they can keep him there as a bigger-sized adult, because that would mean -- his baby sister is seven years younger -- 15 or so. So this was kind of the idea that we discussed together, the transition age 21 out of the house. And so this accounts for the safety and the care from age 7 to age 21.

Q Okay. But my question was, under this regimen of care, the Palmquists could leave the home at any -- any time with like their other daughters or to go to work, and Ethan could stay home with the home health aides?

276

A That's correct.

Q And overnight, at all times from now until he's 21 years old, there would be two people sitting there ready to act in the instance that he had any sort of an outburst at night?

A So I think it's variable on the scheduling, right. So if there would be more care during the day hours when he's running around doing hurricane type of aggressive behavior, as I describe it, and there is a parent home at night, maybe there's only one home healthcare available at night. Versus if they're doing something else or if Dr. Sarah is at the hospital overnight call or she has to be on-call in her home office, then that then could substitute both adults via home healthcare aides there overnight for that supervision.

So this plan on how to enact the 16 hours a day I think is flexible.

Q But under the plan that you have, at all times when Ethan is not in school, there would be two, two health aides. So if you only have one at night, you would need fewer hours, or you could have three during the day. But you have enough hours here to have two providers at every hour of the day, right?

277

A That's what I think is best for safety, for him, the family dynamic, the younger sisters. And that's something I did discuss with Dr. Lisa Settles as well.

Q Home health aides, they help with things like hygiene and toileting; is that correct?

A I would say yes. And the general activities of daily living; dressing, eating, et cetera. We don't rely upon home healthcare aides to administer medication or do the laundry, mow the yard, do the dishes, things like that.

Q Okay. But they would give Ethan meals, put those dishes in the dishwasher, generally kind of do the activity -- do the activities that he might otherwise do for himself during the day as if he were a neurotypical individual. He would go to the bathroom by himself. He would give himself a sandwich. Things like that?

A I mean, I think generally that's a very big -- big statement. Now, there's not a lot of seven-year-olds that I know of that just go in and make a sandwich by themselves, just to kind of contradict that last statement.

But in general, it's activities of daily living. So this is going to be hygiene, showering,

278

bathing, bowel/bladder function. And he has lots of incontinence and very weird things where he poops on the house and self-stimulates naked and goes through multiple clothes and has accidents. And they've already have to change part of their house because of stains, is what they told me. Plus the eating, plus activity.

So, again, when he's running around, there has to be that supervision. So activities of daily living for home health aides, but then again the LVN for the medication administration as a nurse.

Q So can home health aides in Texas provide basic oral medications?

A Home health aides provide basic oral medications. I --

Q I just don't know. Oral medications. Pills.

A So it's my --

MS. PALEY: Charlie, I don't think you want to testify on the record. I'm just asking the doctor. I don't know. I didn't look it up.

MR. PARKER: I was going to say, it's complex.

A It's complex. I don't think -- I don't think they can administer prescription medications.

279

I think they can give a Children's Motrin or Tylenol, an over-the-counter or a Pedialyte, something that you could buy at Target or Walmart. But it's my understanding that we need LVN, LPN, RN level for prescription medications, is my understanding.

Q (BY MS. PALEY) And right now, except for Humira, Ethan's prescription medications are all oral, correct?

A The oral pills and the tincture.

Q And the tincture?

A Yes. Yes.

Q And right now, his parents take care of the administering of the medications, correct?

A I believe in addition to his parents, both sides of maternal, paternal grandparents do that as well at times.

Q Okay. And the total time spent administering medications to Ethan every day, how many minutes would you estimate that takes?

A Well, there's different doses, timeframes and frequency. So it's -- it's a -- I don't know. That's a hard question.

Q I mean, he -- the most he takes any one medication is three times a day, right?

A (Nodded head.)

280

Q And would you, as a parent -- I'm sorry, is that true?

A I can review really quickly. I think that's true. So . . .

Q And generally when administering medications to a child, do you try to -- you know, do all the twice-a-day medications at the same time? Like you do your morning, you do your afternoon?

A Dr. Sarah did not make it sound like it was that easy at all. He runs away from her. He's outside naked. He knows that an oral medicine is inside an applesauce or a peanut butter, spits it out. They try again.

I was of the understanding and observing that it was a very difficult process. So the LVN, LPN four hours should account for that care per day, again, removing the parents from administering any of those medications.

Q Do you believe it takes the parents about four hours a day to administer Ethan's medications?

A So it's not just those four hours for the LVN care. At times, they also may or may not supervise the home health aide. But I think four hours is actually a conservative estimate to have a more well trained healthcare provider in the home

281

during the most troublesome hours.
Q My question is, do you believe it takes Ethan's parents four hours a day to administer his medication?
A I do not think strictly it takes them four hours just for medications.
Q Okay. Thank you.
And do you provide any practice guidelines, peer-reviewed literature or recommendations from Ethan's providers that demonstrate he would need, at all hours of the day, two adult individuals devoted to doing nothing but supervising him, including the time during which he's asleep?
A I don't think there's any specific peer-reviewed articles with his constellation of multitude of diagnoses. And, again, I don't think the treating providers are addressing or prescribing care like I'm recommending, because there's still heavily involved grandparents. Plus he was in ABA as of recently. Plus both parents were working from home, which I understand is changing. So that's the answer.
Q Do you know of any peer-reviewed literature or practice guidelines or other

282

recommendations that suggest that for a child with severe autism that they need 24-hour-a-day, two adult to one child, individual supervision?
A Well, I think that we have to consider his individual case from my recommendations, but I'm not aware of any specific peer-reviewed literature. And just to reiterate, at times these guidelines or practice parameters are not inclusive or exclusive. There's always unique situations at hand, which clearly we're dealing with a severely impaired child with disabilities with a unique situation.
Q Is that a -- is that a no?
A I'm sorry, can -- can I ask you to read back my reply?
Q I think you included, I'm not aware of any specific peer-reviewed literature.
Are you aware of any guidelines? That's just the last part of the question.
A So I think the guidelines that you presented me, again, reviewing them briefly on our downtime, demonstrate a comprehensive approach, a family-centric approach, and they're not inclusive or exclusive. And that's why there's both the art and science of the practice of medicine. We have to evaluate situations at hand as the individual comes.

283

Q But I'm not asking about the guidelines I showed you. I'm asking about whether you're aware of any guidelines that would support your recommendation for the two-to-one, 24-hour-a-day home health aide and LPN care included in your life care plan.
A So I'm not aware of any other specific guidelines or parameters, other than my experience, my recommendations and discussing with Dr. Settles, who was in agreement with this type of supervision.
Q Okay. And you do not regularly act as a treatment coordinator for severely autistic children, right?
A We've covered that. That's correct.
Q Okay. In terms of at-night care, it would be possible to provide other like technology-based or physical bars or barriers to Ethan doing something like leaving his room at night and eloping, correct?
MR. PARKER: Objection as to form.
A Well, I think --
MS. PALEY: Oh, I think your mic --
MR. PARKER: I object as to form. Making a prison for the kid.
A You know, that's a good point. Right now, there -- there are two main locks from the bedroom to the hallway and the bedroom to the bathroom and bars

284

on the windows and tons of damage in his room from ripping, hitting, banging his head on things. And then beyond that, there's a flat mattress on the ground, and that's it. There's nothing else in there because of safety concerns.
I don't think that it's going to be as beneficial to have technology or a camera or, you know, any other -- whatever you're including in physical barriers, because he also is doing things like having incontinence and throwing his poop. And at times Dr. Sarah reported he's actually eaten his feces. And that's really where a lot of this comes from, where you have to have more adult supervision and these therapy recommendations to kind of move forward with this child's care, in my opinion.
MS. PALEY: Could -- I'd just like to know -- ask counsel not to testify on the record there, last comment.
Q (BY MS. PALEY) Can you show me anything in the records that demonstrates frequent nighttime interruptions, such as what you have just noted: Throwing poop, eating poop, things like that?
A This was reported from the family during my home visit. I don't recall any specific treating physicians summarizing that. And I understand why.

285

They're focusing on some other things, like diagnostic tests and medication management and prescriptions, is what I think.

Q Under your plan for home health aides, those -- you have two home health aides present at all times during all of Ethan's other home-based therapies, correct?

A (Nodded head.)

Q Okay. So for at least three hours a day at home, there would be three adults other than his parents or grandparents who were directly supervising and directing Ethan, correct?

A Well, that may be correct, depending on the scheduling. But sometimes a PT/OT might co-treat at the same time, right. I don't know if his grandparents will be there. Somebody has to take care of an approximately 9- to 12-month-old at this point, the baby sister, right. Plus their parents are working.

It's my understanding that Grant has to go back to work. I don't know his hours, but that means off home, back on-site somewhere. And Dr. Sarah also has to be on-site at times. And so there may be overlay. And this plan is something that we discussed with the family. And then this -- this was

286

the higher frequency that I recommended. And then, you know, here we are discussing those specifics.

Q Okay. And I think that you might have taken my question a little bit wrong. I'm saying apart from whenever the parents are at home and whenever the grandparents are there caring for other siblings, setting aside those other people who may be in the home, under your plan at all times Ethan would have at least two dedicated individuals, but sometimes three dedicated individuals, watching him or providing him therapies at any given time?

A That would be correct for the home health aides. And then the frequency or intermittent visits from the therapists at home for their focused OT or speech-language pathology.

Q Okay. And that's three therapies provided each day, 365 days a year, right?

A That's kind of the general recommendation at this time, based upon the information at hand.

Q Okay. So if an LPN or an LVN, four hours a day, 365 days a year, that's -- that's more than a half-time job. If a job is eight hours a day, five days a week, having someone four days, four hours a day every day of the year, that's more than a half-time job for a -- an LPN, correct?

287

A I'm not exactly sure what you're trying to describe right now.

Q Just the total hours that you have for LPN care each year is essentially more than a half-time job.

A So it's not just one person all the time. It would be -- it would be the total of the hours, right? It could be one LVN at four hours. Most likely it's going to be two home health aides to make the 16. It could be two home health aides, six and six for the 12, or one that does a long shift.

That is up to the scheduling of the family and the companies.

Q And I'm not saying it's one individual person. I'm saying you're -- just simple math, 4 times 7, you're having 28 hours a week of nursing care, right?

A Referring to LVN, the four hours a day?

Q Yeah.

A Yes. That's -- 7 times 4 is 28.

Q Okay. So respite care. You include respite care here, Item 7 on Page 250 of your report.

A Yes.

Q Respite care, is that where Ethan would like go to a care center and stay there for,

288

essentially, you know, one -- one weekend a month?

A It's the opposite. It's for his parents and his caregivers.

Q Well, my -- my only experience with respite care is where I had a friend who had two children who had fatal genetic disorders. And I know that for them, the respite care was essentially the children went to, so the parents could be home alone for a weekend.

Is that not what's envisioned here? Would the respite care come to the Palmquists' home?

A So that can be, I guess in your personal experience, an option. Here, it was more for additional care to manage the younger daughters so the parents can have a break, or costs for the parents and the younger daughters to remove themselves from Ethan for the 48 hours every month to try to have a more balanced life and, again, to decrease my major concern of the parents having caregiver burnout for Ethan's high amount of hands-on care.

Q But you're -- during the 48 hours a month of respite care, your assessment also includes full home healthcare and LVN care at the same time, right?

A That's correct.

289

Q Okay. So at that point, during the respite care -- and let's just look at -- did you include a cost survey on respite care? Or did you include just one vendor? Let's look at this.
A Yeah, let me review. I don't recall all the 200 pages here. Again, I think it's variable, depending on if the two younger daughters are there or not. And if they take them out of the house or if it's mom alone versus dad alone and they rotate every month, et cetera.
Q So Page 100 of your report, you have the respite care options. So it's Home Care Options, Synergy Home Care Houston and Temporary Home Care.
So its -- I'm not trying to be dense here. Is the idea that the respite care providers would come into the Palmquists' home?
A Yes. As we discussed that with the family, that then allows them extra coverage for the daughters so they can take a break, whether it's the couple together leaves or just mom, for the 48 hours and then comes back, et cetera.
Q And so once a month, there -- were the respite care providers specifically asked if they would provide care for, say, the other children?
A We did not ask them that specifically.

290

More of the options and then the price for that home healthcare option to allow for the respite care.
Q Okay. Let me look at that.
And so if, say, the Palmquists, Grant and Sarah and their daughters, decided to leave the home for the weekend, 48 hours --
A Uh-huh.
Q -- once a month for respite care, at that point would the Palmquist home have your two home health aides or LPNs, two individuals watching Ethan every hour of the day, and a respite care person staying in the home, and the three hours a day of therapists coming into the home?
A I think if -- if the family and the parents decided to completely do that, both parents and both daughters, then that certainly would have that type of adult supervision and respite care and home health aides in the home for Ethan.
I don't think that that's likely what would occur. But that would be up to the family to decide how they would want to utilize those resources.
Q Okay. So at that point if they did utilize the respite care in that way, you could have up to four people in any given hour dedicated to

291

watching Ethan over the course of the respite care weekend?
A Well, I mean, not necessarily any given hour, right. Because an occupational therapist and speech therapist isn't dedicated to watching Ethan.
Q I said up to. You'd have three and sometimes four, right?
A And then also the respite care likely is going to be there for the other things that the home healthcare aides aren't doing because they're watching Ethan and/or something surrounding the daughters or something else that's going on, if only one adult leaves.
So this is a cost analysis to provide some number on what this would look like for respite care. And it would be up to, again, the family to decide how they want to utilize that.
Q Okay. But if they -- if they utilized it in that way, there would be three to four adults watching Ethan at any -- three to four adults with Ethan, dedicated to Ethan, at any given time during the course of a, say, weekend? I just want to make sure I've got my math right.
A Well, yeah, simple math, 1, 2, 3, 4. But it's just not four adults watching him doing the

292

exact same thing, right. Respite care is going to be in one role. The therapists are doing another role. And then the two home health aides versus the four LVN, LPN are directly helping manage him and taking care of his ADLs and medications.
Q What does the respite care person do if the Palmquists have all left the home?
A They probably, in my opinion, would not then schedule the respite care home health aides or care team to come, because the two daughters and the two parents have left. So, again, it would be up to the family to determine their frequency of utilization with this amount of care I'm recommending.
Q Okay. And if the two parents and the two daughters didn't leave and it was just, you know, one parent goes out for a while, the respite care folks would -- would they essentially act as babysitters for the other children?
A That is one option, babysitters, helping with their normal functioning, meaning like the diapers for the young -- the youngest one or the five-year-old reading books, food prep, things like that. All those normal ADLs that the parents are doing constantly for a child with special needs,

293

Ethan, plus two younger children.
Q But under your plan, the home healthcare aides are doing that for Ethan. So the parents would just be doing those ADLs for their other daughters, right?
A Correct.
Q And so under your plan, the parents would be relieved of those normal parental duties for up to, you know, 48 hours a month using their respite care?
A Essentially that's what we've been discussing, yeah.
MS. PALEY: Okay. Let's go off the record, take a little stretch break. I'm going to look at my --
MR. PARKER: Thank you.
MS. PALEY: Yeah. It's hot in here. I think we're probably all -- oh, let's go off the record.
THE VIDEOGRAPHER: The time is 4:30. We're off the record.
(Recess from 4:30 p.m. to 4:53 p.m.)
THE VIDEOGRAPHER: The time is 4:53. We're back on the record.
Q (BY MS. PALEY) All right. Welcome back,

294

Doctor. We're in the home stretch here.
A Well, I thank you. Welcome back, everyone.
Q All right. Everyone is getting a little stir crazy on this 90-some degree Friday afternoon.
I'm going to mark very briefly Exhibit 16.
(Exhibit Number 16 was marked.)
Q (BY MS. PALEY) This is just a two-pager that I printed off the Avondale House --
A Thank you.
Q It says, Avondale House residential services for individuals with autism.
Do you see that at the top center?
A Yes.
Q Okay. And this is the program that the Palmquists have said they would like Ethan to attend, correct?
A Correct.
Q Okay. And based on your knowledge of Avondale House's offerings, what sorts of services does the special needs group home provide to patients or assist patients with?
A I think it's mostly like activities of daily living so that they can kind of be a little bit more functional. I think there's also some volunteer

295

projects or perhaps even at times they could be employed. So that's kind of my understanding when they're 21 years age and older, full-time living here at the Avondale House.
Q Okay. And activities of daily living, that's things like cooking, cleaning, laundry, stuff like that?
A Yeah. I think on Page 2, it or -- yes, Page 2, it kind of says some of that.
Q Maybe it even says that, right?
A Yeah.
Q Okay. And I think it also -- even some assistance with hygiene as well, right?
A Bath, shower, hygiene, toothbrush, et cetera, yes.
Q Okay. And in -- in getting the $13,000 a month figure from Avondale House, did the individuals who called this school ask of whoever they spoke to what families pay on average after any sort of grants or aid or discounts?
A That's not my understanding. I don't think that was asked. I think it was just, What is the self-pay rate.
Q Okay. Just a little bit of here and there cleanup -- not cleanup, but a few questions on the

296

variety of areas of your report. On Page 84, you list EGDs. As I understand, that's the sort of scoping from the top from the throat into the stomach?
A And the small intestine. That's correct.
Q Okay. And I'll turn to Page 84 so we're looking at the same thing. Also on Page 144, you have your chart for how frequently Ethan would get an EGD under your plan.
As I understand it, it's one every two years from now until he's -- until he passes away. And that's Page 144.
A Yes. We have that as a duration of 70 years and an interval of once every two years.
Q And Ethan had an EGD in 2019; is that right?
A That's what my memory serves me. I don't have any reason to contradict that at this moment.
Q Okay. And was that part of determining whether like he needed Humira or -- I should strike that.
What was the purpose -- purpose of the EGD that he had in '19?
A I think we touched on that at the very, very beginning. I think that's when the

297

gastroenterologist does the objective visualization, the scope. I don't want to say it to confuse everybody, esophagogastroduodenoscopy.

Q That's why I said EGD.

A So that's visualizing the lesions, and then that grades the extent of lesions, involvement, depth. And then, you know, after you get a diagnosis, then they recommend the treatment, medications, et cetera.

Q And so that was a -- essentially an exploratory and diagnostic procedure?

A Sure.

Q Okay. Can you point me to anything in the records demonstrating that Ethan's providers have recommended repeated EGDs?

A Just the discussion with Dr. Krigsman. Along with most patients with inflammatory bowel disease and Crohn's disease do get repeat, you know, at serial intervals, to check severity of the disease.

Q Did you and Dr. Krigsman discuss the specific frequency of EGDs that you've recommended?

A I don't recall if we discussed every year versus every two years or every five years.

Q And do you routinely order EGDs as part of

298

your medical practice?

A Not routine -- not routinely. I definite do in the hospital at times, when we have a significant clinical concern. But that then is transferred to the GI specialist that does the procedure.

Q Okay. And are those concerns sort of, you know, exploratory and hopefully diagnostic of whatever is going on?

A Bleeding ulcers, anemia, masses, tumors, severe pain, unresponsive to medication management, et cetera.

Q Okay. And let's look, then, here -- also on Page 144 -- Item 6. You have essentially repeated EEGs also every other year but starting at age 10; is that correct?

A Okay. So Item Number 6?

Q Item Number 6 on Page 144.

A Yep. Age 10. One EEG every two years.

Q And these questions will sound a little repetitive to you, but can you point me to anything in the medical records that indicates Ethan's providers have recommended routine monitoring with EEGs on the frequency of approximately the spaces?

A I don't recall those recommendations. And

299

they typically won't recommend that unless it's like a narrative report or they're a retained expert or we're doing a life care plan. But I did discuss repeat EEG to monitor and/or diagnose seizure severity with the treating neurologist.

Q And that's Dr. Rotenberg?

A Correct.

Q Okay. And did you and Dr. Rotenberg discuss the -- specifically the frequency with which you were recommending repeated EEGs?

A Not this specific frequency, but moving from pretty frequent -- like the annual one when he's younger -- to less frequent, one every two years, after the age of 10.

Q Okay. Let's look at Page 213 of your report, and I want to direct you to Item 9, and this is just a grab bag of items that we're covering.

MR. PARKER: We've been on this page before.

MS. PALEY: We have.

A Sure. Yeah. Go to for it.

Q (BY MS. PALEY) So Item 9 on Page 213 is occupational therapy sensory integration.

A Uh-huh.

Q And you recommend, is it weekly sensory

300

integration therapy for Ethan until he's 18 years old?

A Age 7 for 11 years once a week, correct.

Q Okay. Do you know if the Avondale House school provides any sensory integration services?

A I'm uncertain if they provide the occupational therapist. I think part of being in school at that type of special needs facility, yes, you're going to be touching things and hearing things and seeing things for sensory. But this one is a little bit different. Specific OT sensory integration is what I was conveying here.

Q Okay. And I think the brief answer is you're uncertain if they provide an occupational therapist at Avondale school for sensory integration?

A Correct.

Q I know you picked 45-minute -- sorry. Strike that.

Can you provide any basis in the medical records suggesting that Ethan needs weekly sensory integration therapy?

A I mean, other than the entire medical records of his impairments and diagnoses that leads me then to recommend the sensory integration to help him. I don't recall if this has been ordered by any

301

other treating physician at this time.
Q Okay. And can you -- have you surveyed the medical literature, the peer-reviewed literature to determine whether sensory integration has been found to be effective?
A I have not.
Q Okay. Let's look very quickly -- I'm going to mark as -- oh. Oh, I think we already -- we already marked it. I don't know what number it was, but it was the Practice Parameters in Autism, that article that we took a five-minute break to read.
A Exhibit 11.
Q Exhibit 11. Thank you.
Okay. And so you've spent a little bit of time on this, right?
A Yes.
Q Can you look on Page 245. Now, the bottom right corner of 245 is where we had discussed earlier psychosocial intervention, right?
A Yes.
Q Okay. The next sentence, which I hadn't read out loud, I'll read now. Studies of sensory orient -- sensory-oriented interventions, such as auditory integration training, sensory integration therapy and touch therapy massage have -- contains

302

methodological flaws and have not yet to show replicable improvements.
Did I read that correctly?
A Yes. I see that.
Q Okay. Do you have any evidence that would contradict these findings from the American Academy of Child and Adolescent Psychiatry regarding the effectiveness of sensory integration therapy?
A So the way I read this is that they did not have a replicable improvement, which means that the study was not repeated, and there's extreme difficulty in pediatric autism studies. I would need to just review the actual studies they're referencing, 108, 109.
Q Okay. But you didn't review those studies as part of preparing your life care plan, right?
A That's correct.
Q Okay. I'm going to mark as Exhibit 17 an article by Susan Hyman, et al.
(Exhibit Number 17 was marked.)
Q (BY MS. PALEY) I actually shouldn't say article. It's listed as a clinical report in the American Academy of Pediatrics. At the top it says, Clinical Report, Guidance For the Clinician in Rendering Pediatric Care, American Academy of

303

Pediatrics. And it says, Identification, evaluation and management of children with autism spectrum disorder.
Did I read that correctly?
A Yes.
Q And the publication date at the bottom left is January of 2020?
A Yes.
Q Okay. Let's look at Page 26. Actually -- yeah, Page 26. Now, starting in the left-hand column on Page 26, do you see it begins a section called, Other therapeutic interventions?
A Yes.
Q Okay. And then in a slightly different font, it -- an italicized font, it lists a range of specific interventions. It starts with Speech and Language Interventions.
Do you see that?
A Yes.
Q And then the next section, which is in the right-hand column on Page 26, is Motor Therapies. Very bottom.
A Yes.
Q Okay. Moving on to Page 27, the center column top is Sensory Therapies, right?

304

A Yes.
Q Okay. Now, within that Sensory Therapies category, let's look at the right column. Okay. And I'm going to read about a third of the way, almost halfway down the column, a sentence that says, Although sensory-based therapies are among the most commonly requested therapies by caregivers, the evidence supporting their general use remains currently limited.
Do you see that?
A Yes, I see that.
Q And just to be sure, do you have any more up-to-date evidence beyond this 2020 article from the American Academy of Pediatrics that would suggest that sensory therapies have been found to be, you know, consistently helpful for children with autism?
A Just -- I'm just looking at the articles that they're citing, 378 and 379. No. I don't have any other specific articles. I'd be curious to read these and understand the specific type of research and then where this meta-analysis by Dr. Hyman concluding that it's limited.
Q Okay. But you didn't review those in preparing your life care plan, right?
A That's correct.

305

Q Okay. Let's just mark one more, for the fun of it.
A As with any . . .
Q Exhibit 18.
(Exhibit Number 18 was marked.)
Q (BY MS. PALEY) Sorry. There we go.
Now, Exhibit 18 is in the journal of Pediatrics. Do you see that?
A Yes, at the bottom. Pediatrics, November 2012.
Q Uh-huh. And the title is Non-Medical Interventions for Children with ASD, Recommended Guidelines and Further Research Needs. Do you see that?
A Yes.
Q Okay. Let's see. It looks like the authors include folks from the Rand Corporation and the Center For Autism Research and Training at UCLA. I just wanted to give you a minute if you want to review this. But I'll point your attention to Page S-172. And the top middle column is titled Results.
A Yes.
Q And it says, Systematic review of scientific evidence. Do you see that?
A Uh-huh.

306

Q Okay. And then here if you -- if you scan this, do you see that they're discussing sort of a summary of the -- sort of the trials so far in certain kinds of therapies in children with autism?
A Yep.
Q Let's look at the right-hand column, that first paragraph, which is a trail-over from the middle column. And I just want to look at the penultimate sentence. It says, Auditory integration therapy was found ineffective in four of five trials.
Do you see that?
A In the top right?
Q S-172.
A Oh, I see it, yes, now, the last sentence. Auditory integration training was found ineffective in four of five trials. Further details about results are available in the full report.
Q Okay. And if you turn to Page S-175 in the middle column. The middle column -- well, if you look to the left, there's a heading Programs for Individuals with Limited or No Language.
Do you see that? It's very light print. S-175, left-hand column.
A Yes.
Q Okay. And Ethan has limited or no

307

language; is that correct?
A Correct.
Q Okay. Let's look at the middle column there, which is a trail-over from the Programs for Individuals with Limited or No Language. And do you see the second paragraph says, Small but well-designed controlled trials found auditory integration therapy ineffective in addressing any of the core deficits of autism. Guideline: Given the current state of the scientific evidence, auditory integration therapy cannot be recommended to address the core deficits of autism.
Do you see that, Doctor?
A Is it still under the same Interventions for Children with Limited Language?
Q I believe so. Left-hand column has that -- that header. The sentence at the bottom of the left-hand column follows into the center column. And then --
A I'm just not seeing where you are. I'm sorry.
Q I'll hold up a highlighted copy so you can see. This is S-175.
A Oh.
Q And this is the language I'm looking at.

308

A I'm sorry. I'm on the wrong --
Q Wrong page?
A The 3 looked like 5.
Q Ah.
A No wonder. Okay. All right. Let me see the pink. Got it.
Q Yeah.
A Small but well-designed controlled trials -- got it.
Q Do you have any, you know, literature or guidelines that would contradict this finding that auditory integration therapy cannot be recommended to address the core deficits of autism?
A I don't have anything handy or literature to refute this statement.
Q And -- strike that. Sorry.
Let's move off of sensory integration therapy. And I want to ask you a couple of questions about lab tests. Your life care plan includes a range of lab studies that you believe Ethan will possibly need over the course of his life; is that right?
A Correct.
Q Okay. And we can look at your report, Page 181, to see your summary chart of the

309

recommended tests and their frequency.
A Okay.
Q Okay. And similar to my earlier questions about things like, you know, going to the dentist or going to the GP, have you -- in recommending these frequencies, have you tried to sort of back out or subtract whatever frequency a neurotypical person might pursue any of these tests?
And I'll give an example. If, you know, if a neurotypical person would get a complete blood count once a year as part an annual exam, do you subtract that from your frequency for Ethan to come up with, you know, what's the difference between Ethan and a neurotypical person?
A So a lot of questions that -- in that statement. Typically children without significant diagnoses and prescription medications don't need a complete blood count. Complete blood count, CMP, urinalysis, really all of these were discussed briefly with Dr. Krigsman, because being on Humira has potential risks and we need to identify his blood work for things like infection or low white blood cells or low platelets. Those are the main Item 1 and 2 blood works, four times a year, as well as 10 and 11, once a year because of the monoclonal

310

antibody for the Crohn's disease.
And then, in general, yes, if an adult were to have an annual CBC blood count once a year in addition to that annual workup, I'm also recommending the four per year for life.
Q Okay. So for Ethan it's essentially saying he needs five, but your average person will have one, so we're going to attribute four to the life care plan? Or do you think he just needs four?
A We could say he needs six, you know, every two months if he has abnormalities with these medications. Prescription medications can definitely affect his entire system. That's, again, why we do screening with patients on these prescription medications.
So I'm recommending that this is the frequency that we're looking at on this page.
Q Okay. And I'm just trying to understand like how you very specifically came up with four. If it --
A Okay.
Q -- was something that just sort of seemed probably a safe frequency? Or is it based on some sort of, you know, particular guidelines or recommendations, things like that?

311

A Yeah. Every three months, I'm getting a blood count and a chemistry panel when you're on Humira. It seems pretty standard for me, in my experience, along with Dr. Krigsman confirmed that we needed to maintain a high-frequency of screening blood work, along with the other options, 10 and 11, specifically related to these monoclonal antibody trough levels. And then an antibody antibody is what Number 11 is. It's an antibody to the antibody.
Q Sorry. Just a second.
You said it seemed the complete blood count every three months seems pretty standard to me in my experience. How often are you monitoring patients on Humira?
A So I don't do the monitoring, but they definitely report to me what's going on, reading things, continuing medical education and then also discussing things with GI doctors, whether it's in the clinic, the hospital or, in this case, Dr. Krigsman.
So four times a year is every three months to do basic blood work, which is a standard of care, is my understanding, when you're on a monoclonal antibody for inflammatory bowel disease.
Q And when you say "they," are you saying

312

patients?
A They, regarding gastroenterologists or they, as in patients?
Q You say, They definitely report to me on what's going on, reading things.
A Yeah. So patients will tell me what they're doing when they come in and visit regarding their other diagnoses and their other physicians. And then in the hospital, I have to have that complete understanding of their full history, all their medical comorbidities and kind of where is the frequency of normal, you know, blood work, when was the last one, we have to do it today, et cetera.
So four times a year is -- is pretty consistent with my understanding. Again, this is something I discussed with Dr. Krigsman, the treating GI doctor.
Q Okay. But then you didn't discuss the very specific frequencies with Dr. Krigsman, right?
A We -- we likely did discuss quarterly here on this one.
Q Okay. And your life care plan also calls for a micronutrient test profile, right? That's Item 5?
A Yes. I think that was a recommendation

313

from one of the treating providers as well.
Q Okay. And what's generally included in a micronutrient test profile?
A So in my experience, there are things that are not as prominent compared to the other blood work, like a complete blood count or comprehensive metabolic panel which tells me like the basic salt, sodium, potassium. So micronutrients could be enzymes, different things like the levels of vitamins, minerals. So all of those would be -- even micronutrients -- that we could test for to identify if he has any deficiencies.
Q And I'm going to mark probably one last exhibit. I think we're on 20?
THE REPORTER: 19.
MS. PALEY: 19. Thank you. This is why they don't let me monitor my own exhibits or keep track. All right.
(Exhibit Number 19 was marked.)
Q (BY MS. PALEY) I looked online to see what a micronutrient test profile might include. And I found this from DHA Laboratory. You see it says Micronutrient Test on the front?
A Yes.
Q And then if you look in here a couple

314

pages in, it tells you, you know, there's something about the clinical applications, and then it says Analytes.
And those are the things that are being analyzed, right?
A That would be my understanding, yes.
Q Okay. And if you take a quick look, are the analytes that you see here, you know, pretty consistent with what a micronutrient test profile would include?
A Vitamins, minerals, glutathione, fatty acids, chromium. Yep.
Q And is Vitamin D3 the same as Vitamin D?
A Is Vitamin D3 the same as Vitamin D. Generally speaking, yes.
Q Okay. This micronutrient test profile includes Vitamin B12, right?
A This specific DHA Laboratory brand, yes, does say -- does say B12.
Q Okay. And you said that what's included in here is pretty consistent with what you would expect in a micronutrient test profile, right?
A This is pretty comprehensive.
Q All right. So you're -- looking back to your report, back to Page 181 of the laboratory

315

studies?
A Uh-huh.
Q In addition to the micronutrient test profile once a year, you also recommend B12 monitoring once a year, right?
A Correct.
Q At $131.62 per, for 70 years, right?
A Correct.
Q You also recommend Vitamin D level monitoring once a year, right?
A Correct.
Q Now, this micronutrient test profile also includes Vitamin D, doesn't it?
A That's what I'm seeing here. Now, I guess I would have a question is, are all of these able to be analyzed at one time with one blood draw sending it to the lab?
Q Well, I don't know. Maybe you can look through there and see if it says that they can.
But if you flip the page in the mineral section --
A Uh-huh.
Q -- you see it also includes zinc, right? Manganese, copper and zinc?
A Yes.

316

Q Okay. And your plan also separately includes annual monitoring of zinc levels, right?
A Correct.
Q Okay. So if the micronutrient test profile calls -- measures Vitamin B12, Vitamin D and zinc, you know, annually, then you don't need to separately do blood draws for each of those three items annually as well, right?
A If it was this comprehensive from DHA that included everything, then this -- this absolutely would suffice for one lab report annually for everything.
Q Okay. And maybe particularly with a patient like Ethan where there are some, you know, challenges with blood draws and it probably causes some stress, you might want to minimize how frequently you're drawing blood, right?
A Well, I mean, if we're doing one blood draw and eight tubes for this panel or eight tubes for what I recommended, essentially that's the same amount of blood, once a year at the same time. So I think that part is comparable. Yes, in general, minimizing the amount of procedures and blood draw. And that kind of also I think leads into some of the clonidine and some of the other medication

317

recommendations.
Q Okay. And you don't -- you don't know how many tubes this DHA profile -- this DHA laboratory requires, right? You don't know if it's one or eight or what?
A In my experience, I mean, we deal with blood draw and blood tubes frequently, almost daily. I don't think that this is possible for one tube of blood to identify 30-plus different micronutrients. And I'm not seeing here a volume, a milliliter or a number of tubes.
Q Okay. So you just -- you just can't say one way or the other how many tubes or what the volume is?
A I mean, I would -- I would think this is more than one, but I would -- yeah, we'd have to figure out specifically from -- from the laboratory and which type of tubes are needed for this.
Q Okay. You also include lead levels. Just one lead level measurement this year when Ethan is 7, is that blood lead level?
A I was thinking more that would be a blood lead level.
Q Okay. And why the blood lead level?
A I think I added that because I didn't

318

recall seeing that previously in the specific lab data reports.
Q Okay. So you haven't seen any of Ethan's blood lead level --
A You know, I'm trying to think why I added that --
Q -- measures?
A -- for just one time now. I think that might have been the reason. I have to look back at those reports.
Q Okay. But it sounds like, sitting here today, you don't recall seeing blood lead level analyses for Ethan?
A That is true.
Q Okay.
A It doesn't look like it's on this micronutrient array panel. Okay.
Q Okay. If you can give me five minutes to just look at my pages, I may be done possibly. But I just need to take --
MR. PARKER: Sure.
MS. PALEY: Are you going to have questions?
MR. PARKER: Oh, yeah. About an hour's worth.

319

MS. PALEY: Well, hey, man, I'm here until 6:30 in the morning.
MR. PARKER: These people would kill me.
MS. PALEY: All right. So let's go off the record.
THE VIDEOGRAPHER: Okay. The time is 5:26. We're off the record.
(Recess from 5:26 p.m. to 5:35 p.m.)
THE VIDEOGRAPHER: The time is 5:35. We're back on the record.
Q (BY MS. PALEY) All right. Doctor, I promise to be brief. I will be brief here.
Your report on Page 98 includes your cost survey for the home health aide providers. Do you see that?
A Yes, ma'am.
Q Okay. And the rates that are here that range from like $21 an hour to $35 an hour, just so I understand what the rates are, those would be the rates that the Palmquists would pay to the home health aide agency to cover the home health aide but also just whatever other administrative costs are included in engaging the agency; is that right?
A That's my understanding.
Q Okay. And -- I actually have one more

320

question. I promise you, this is the end.
In putting together these estimates or in selecting these particular providers for your cost survey, were these providers also taken from the PLCP sort of database or spreadsheet of Houston area providers?
A Regarding home healthcare aides?
Q Yes.
A You know, I'm not sure. I think -- I think this was different where they likely called. But I'd have to -- I'd have to speak with my staff to clarify.
Q Okay. So do you have any sense of the methodology that was used to determine who to call?
A There likely is some list of the providers. I don't have access to that, but -- given the amount of work in Houston and the state of Texas. But I can't speculate on that. So I'd have to talk to my staff and specifically ask them the methodology.
In the past, my understanding was they -- they would look at the different businesses via the location, start calling and then get the hourly rates that way.
MS. PALEY: Okay. That's all. It's a

321

wrap.
MR. PARKER: Great. We reserve our questions until time of trial. Thank you all.
THE VIDEOGRAPHER: Before we go off the record, I need to know. Do either of you need copies of the video?
MS. PALEY: Not right now, but I'm sure we will at some point.
MR. PARKER: Whenever they order one, I want one.
MS. PALEY: That's the right answer, Charlie.
THE REPORTER: And what about the transcript?
MR. PARKER: What's that?
THE REPORTER: A transcript?
MR. PARKER: Oh, a transcript, yes. I do not need an expedited copy, just final transcript.
THE REPORTER: Do you want a rough draft?
MR. PARKER: No, no rough draft.
MS. PALEY: And what's the turnaround on regular time for the final?
THE REPORTER: I will have to look that up for you.
MS. PALEY: Let's take a rough, but it

322

does not need to be this weekend. Early next week is fine. And then we'll take a regular time final.
THE REPORTER: Thank you.
THE DEPONENT: Silly question. So --
MS. PALEY: We'll go off the record.
THE VIDEOGRAPHER: Are we through with orders?
MS. PALEY: Yes.
THE REPORTER: Yes.
THE VIDEOGRAPHER: This concludes today's proceedings. The time is 5:38. We're off the record.
WHEREUPON, the within proceedings were concluded at the approximate hour of 5:38 p.m. on June 17, 2022.

323

I, MATTHEW HYZY, do hereby certify that I have read the foregoing transcript and that the same and accompanying amendment sheets, if any, constitute a true and complete record of my testimony.

_____
Signature of Deponent

( ) No Amendments
( ) Amendments Attached
Acknowledged before me this
_____ day of _____, 2022.

Notary Public:_____
My commission expires_____
Seal:

BJD

324

STATE OF COLORADO)
) ss. REPORTER'S CERTIFICATE
COUNTY OF DENVER)
I, Barbara J. Davalos, do hereby certify that I am a Registered Merit Reporter and Certified Realtime Reporter within and for the State of Colorado; that previous to the commencement of the examination the deponent was duly sworn to testify to the truth.
I further certify that this deposition was taken in shorthand by me at the time and place herein set forth, that it was thereafter reduced to typewritten form, and that the foregoing constitutes a true and correct transcript.
I further certify that I am not related to, employed by, nor of counsel for any of the parties or attorneys herein, nor otherwise interested in the result of the within action.
In witness whereof, I have affixed my signature this 27th day of June, 2022.

Barbara J. Davalos, RMR, CRR
216 - 16th Street, Suite 600
Denver, Colorado 80202